# Peer Support as a Public Health Approach to Addressing Suicide: Current Theory and Research

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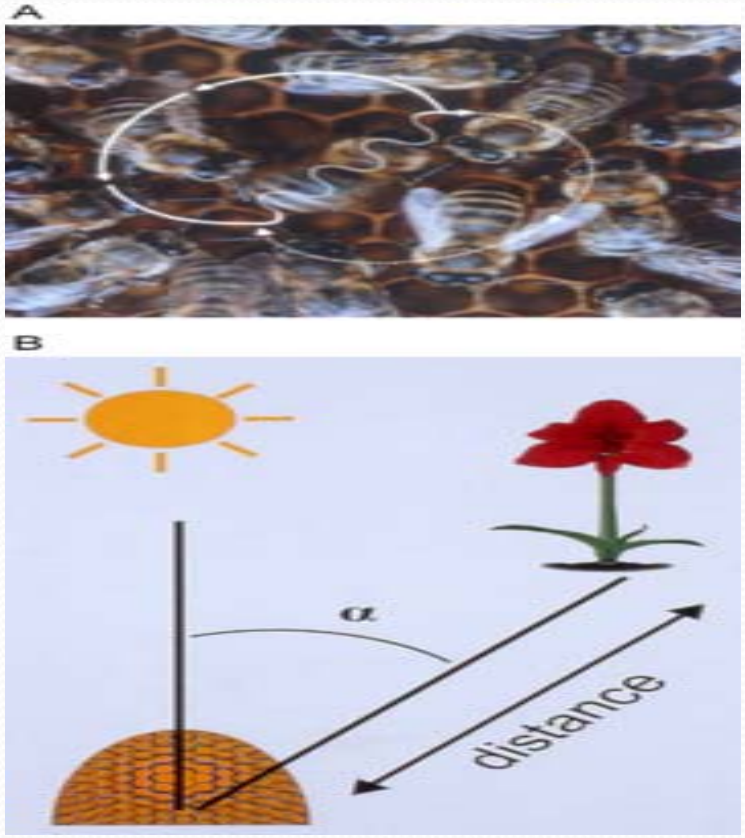
# Presentation Overview

- Current theory and policy on peer support in mental health
- Current research on the effectiveness of peer support interventions
- Describe peer specialists as an emerging workforce in behavioral health, both in the VA and public mental health sector
- Current approaches to peer support training
- Research on the effectiveness of training
- Research on peer specialist activities
- Possible roles for peer specialists in suicide prevention
- Research on barriers to the implementation of peer support and solutions

# Mutual Aid As Old As Time




Honey Bee Waggle Dance

# Why Do People Seek Out Peer Support?

- Social Comparison Theory (Festinger, 1954)People seek out interactions with others who have similar experiences in times of crisis/stress to regain a sense of normalcy.
  - Upward comparisons increase self-improvement (e.g., develop skills) and self-enhancement (e.g., increase sense of hope and decrease fears) efforts.
  - Downward comparisons are ego enhancing and maintain positive affect by providing examples of how bad things could be.
- Why do soldiers and veterans seek peer support?
  - Brotherhood and bonding is essential
  - Members take care of one another
  - Common experiences and culture

# Additional theories underlying the effectiveness of peer support (Salzer & MHASP Best Practices Team, 2002)

| Theory | Description |
|---|---|
| Social Learning Theory (Bandura) | Behavior change is more likely when modeling is provided by peers than non-peers.<br>Peers model coping and health-enhancing behaviors.<br>Peers enhance self-efficacy that one can change behavior. |
| Social Support Theories | Social support enhances access to instrumental, psychological, and social resources through 5 types of support:<br>Emotional (someone to confide in, provides esteem, reassurance, attachment and intimacy)<br>Instrumental (services, money, transportation)<br>Informational (advice/guidance, help with problem-solving and evaluation of behavior and alternative actions)<br>Companionship (belonging, socializing, feeling connected to others)<br>Validation (feedback, social comparison). |
| Experiential Knowledge (Borkman, 1999) | Personal experience with a phenomenon (e.g., illness) leads to an understanding and knowledge base that is unique and valuable compared to knowledge acquired through research and observation (practice)<br>Experiential knowledge leads to different policy and intervention approaches |
| Helper-Therapy Principle (Riessman, 1965; Skovholt, 1974) | Helping others is beneficial through:<br>1) Increased sense of interpersonal competence as a result of making an impact on another's life;<br>2) Development of a sense of equality in giving and taking between himself or herself and others<br>3) Helper gains new personally relevant knowledge while helping<br>4) Helper receives social approval from the person they help and others. |



**Salzer, M.S.**, & Mental Health Association of Southeastern Pennsylvania Best Practices Team (2002). Consumer-Delivered Services as a Best Practice in Mental Health Care and the Development of Practice Guidelines. Psychiatric Rehabilitation Skills, 6, 355-382.

# Peer Support Research Evidence Base

- Humphreys (1997) Individual and social benefits of mutual-aid self-help groups. *Social Policy*
- Davidson et al. (1999) Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*
- Van Tosh & del Vecchio (2000) Consumer-operated self-help programs: A technical report. *CMHS*
- Solomon & Draine (2001) The state of knowledge of the effectiveness of consumer-provided services. *Psychiatric Rehabilitation Journal*

# Federal Recognition of Peer Support

1978: President Carter's Commission on Mental Health offered early federal recognition that "groups composed of individuals with mental or emotional problems" were being formed around the country

1987: Surgeon General's Report recommended strategies for promoting self-help groups

1999: Surgeon General's Report promotes self-help groups and consumer-run services

Pre-2001: Peer support services funded by states and counties

2001: CMS Funding of Peer Support in GA and AZ

2003: The President's New Freedom Commission on Mental Health promotes consumer-operated services

2004: VA strategic plan agenda recommendation "Hire veterans as Peer/Mental Health Para Professionals." (Commission Rec. 2-3.18 &19, Appendix 1).

2007: CMS guidance letter to states on peer support services

2008: *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics* states that "all veterans with SMI [serious mental illnesses] must have access to Peer Support (2, pg. 28)".

# Peer/Paraprofessional Support and Suicide Prevention

- Adolescence
- College students
- Police Officers (e.g., POPPA – Police Organization Providing Peer Assistance)
- Peer support crisis response teams
- Older adults
- U.S. Military (Yosick & Brown, *Proceedings Magazine*, Feb. 2011)

# Peers As Part of Suicide Prevention Efforts in the VA

- U.S. Code: Title 38, p.2, ch.17, subch. II, stat 1720F – Comprehensive program for suicide prevention among veterans
- "The secretary shall develop and carry out a comprehensive program designed to reduce the incidence of suicide among veterans incorporating the components described in this section.
  - (j) **Peer Support Counseling Program.—** (1) In carrying out the comprehensive program, the Secretary may establish and carry out a peer support counseling program, under which veterans shall be permitted to volunteer as peer counselors—
  - (A) to assist other veterans with issues related to mental health and readjustment; and
  - (B) to conduct outreach to veterans and the families of veterans.

# U.S. Code pertaining to peer counselors with veterans

(2) In carrying out the peer support counseling program under this subsection, the Secretary shall provide adequate training for peer counselors.

# Medicaid Reimbursement and CPS Requirement

- CMS guidance letter (2007) comments on:
  - supervision of peer support providers by a "competent mental health professional,"
  - peer support services should be coordinated with other services in order to achieve person-centered, individualized goals,
  - "Peer support providers must complete training and certification as defined by the State," and, like other certified providers, obtain continuing education.

# CPS Training Programs

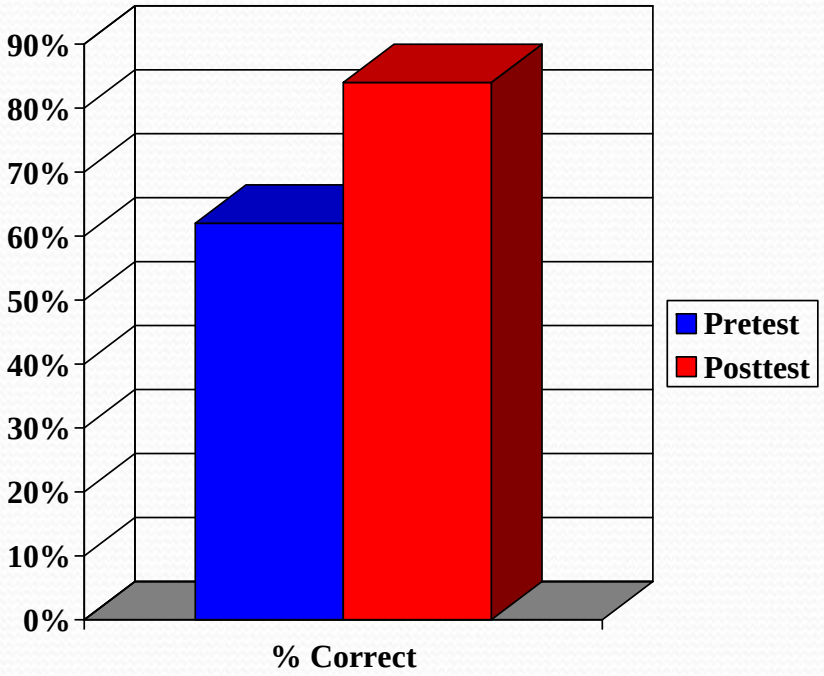
- Many CPS training programs in existence
  - Katz and Salzer (2006) had 13 programs respond to their request for information
  - The Western New York Care Coordination Program (2008) described another 6 programs
- CMHS/SAMHSA (2005) published CPS training competencies covering the following domains
  - An understanding of their job and the skills to do the job
  - An understanding of the recovery process and how to use their own recovery story to help others
  - An understanding of, and ability to, establish healing relationships
  - An understanding of the importance of and having the ability to take care of oneself

# CPS Training Outcomes: Graduation

- All 141 individuals (100%) who enrolled successfully completed the Meta Services Peer Provider program (Hutchinson et al, 2006)
- 69 out of the 73 (95%) individuals accepted in the Recovery Support Specialist Institute graduated (Stoneking & McGuffin, 2007)
- 72 out of 74 (97%) individuals enrolled in training provided by the Institute on Recovery and Community Integration successfully completed the program (Salzer et al., 2009)
- 100 out of 137 (73%) of the peers who were accepted and attended the intensive Kansas Consumers as Providers program graduated (Ratzlaff et al., 2006)

# CPS Training Outcomes

- Training associated with positive psychological outcomes and personal growth (Hutchinson et al., 2006; Ratzlaff et al., 2006).



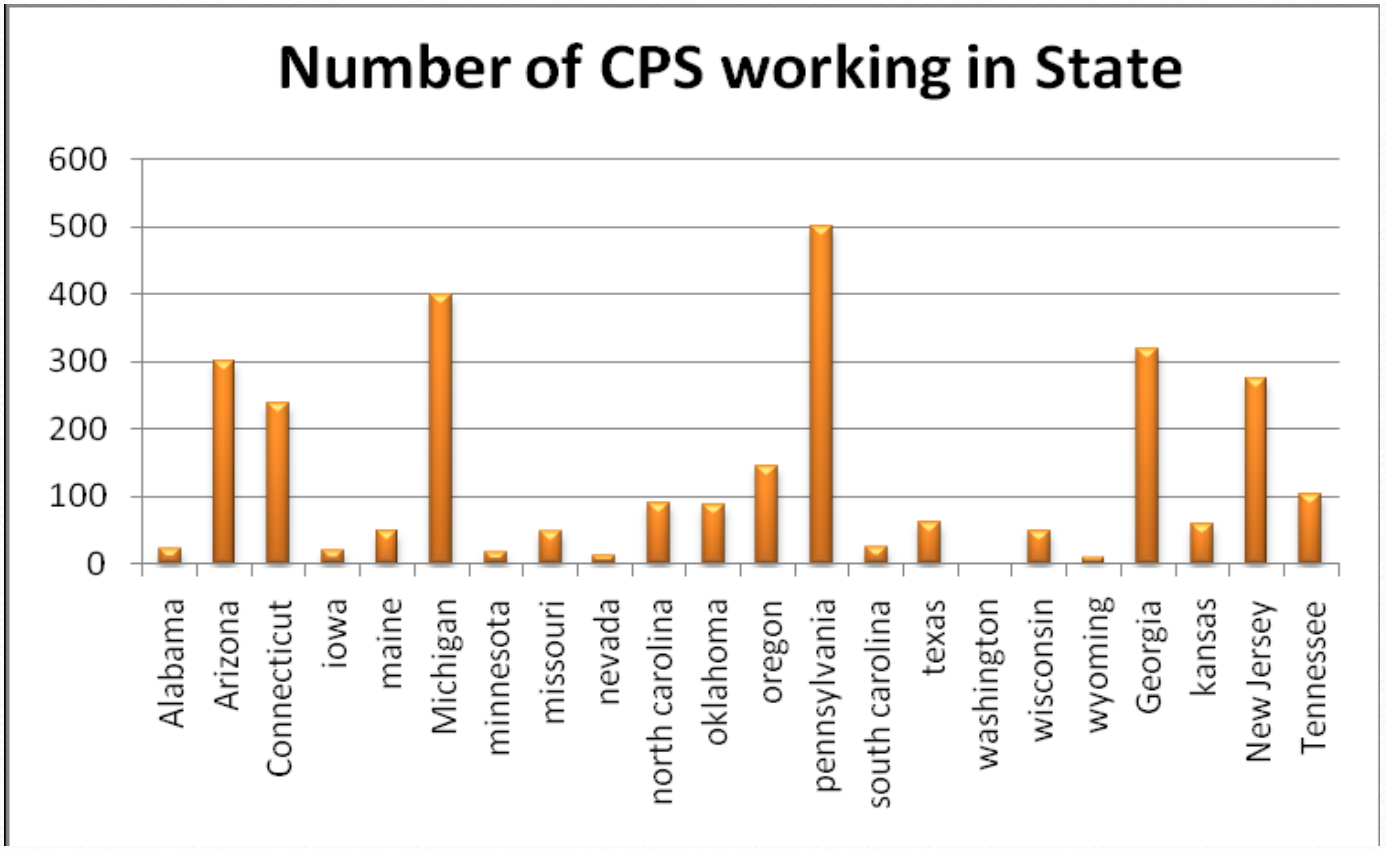

Increased knowledge* (Salzer et al., 2009)

- Statistically significant at p<.001.
- 32% scored >70% correct on pretest.
- 96% scored >70% correct on posttest.

**Salzer, M.S.,** Katz, J., Kidwell, B., Federici, M., & Ward-Colasante, C. (2009). Pennsylvania Certified Peer Specialist Initiative: Training, Employment, and Work Satisfaction Outcomes. Psychiatric Rehabilitation Journal, 32, 293-297.

# CPS Training Employment Outcomes

- 89% of participants were employed 1-year after completing CPS training (Hutchinson et al., 2006).
- 77% working as a CPS 1-year post-training (Salzer et al., 2009)




Daniels, A., Grant, E., Filson, B., Powell, I., Fricks, L., Goodale, L. (Ed), Pillars of Peer Support: Transforming Mental Health Systems of Care Through Peer Support Services, www.pillarsofpeersupport.org; January, 2010.

# National Survey of CPS*

- 291 respondents (6/08 – 3/09)
- 33% male, 66% female, and 1% transgender.

| **Race** | **N** | **%** |
|---|---|---|
| Asian/Pacific Islander/Hawaiian Native | 3 | 1% |
| Black/African American | 29 | 12% |
| Hispanic/Latino | 8 | 3% |
| Multiracial | 8 | 4% |
| Native American/American Indian | 3 | 1% |
| White/Caucasian | 198 | 79% |

* Survey conducted by Salzer, Brusilovskiy, and Schwenk

# Agencies and Programs

- Participants came from 27 states and more than 190 different agencies

- Pennsylvania and Michigan had the greatest number of participants (70 and 51, respectively)

- The highest number of participants from any one agency was 10.

# Employment

- CPS respondents employed an average of 23.8 months
  - The range in months is from 1 month to 126 months (10.5 years)
- Hours worked per week
  - Average of 29.6 hours/week
  - Range from 3 to 50 hours
  - 111 peer specialists (58%) worked full-time (35 hours or more per week)

# CPS Job Titles

- 105 job titles out of 291 respondents
- The most common job title was “Certified peer specialist” reported by 60 individuals
  - 28 individuals reported a close variation -- “Certified peer support specialist.”
- The second most common title was “Peer support specialist” reported by 42 individuals
  - 35 other individuals reported a job title that also started with “Peer…” with endings such as “advocate,” “counselor,” “specialist, and “mentor.”

# What do CPS Do?

- The primary responsibility of the certified peer specialist is to (Georgia Division of Mental Health as cited in Sabin & Daniels, 2003):
  - "…assist consumers in regaining control over their own lives and control over their recovery processes"
  - ".model competence and the possibility of recovery…"
  - "….assist consumers in developing the perspective and skills that facilitate recovery"

# What do CPS do? – VA Data

- Hebert et al. (2008) – Data gathered from key informants at 25 VA facilities with peer specialists (paid and unpaid)
  - 76% of the programs involved peers working as part of a traditional program and 24% involved in independent peer support programs.
  - Activities
    - Ten programs (40%) reported that the peer services consisted of only peer support groups.
    - Nine programs (36%) reported that all services were 1:1 peer mentoring, outreach, or counseling services.
    - Six programs (24%) described offering a combination of services, including 1:1 and group, warmline and 1:1, and peer drop in center and 1:1.

# What do CPS do? – VA Data

- Chinman et al. (2008) – Focus group data from four sites
- Peer specialist roles were varied, but generally involved direct service:
  - assisting with or conducting new patient orientation;
  - leading many types of groups (support, illness management, 12 step, and social or quality of life);
  - completing intakes, screenings, and treatment planning;
  - Helping people find housing;
  - accompanying people to community activities
  - advocacy for needed services
  - providing transportation
  - Helping people with basic daily needs
  - Program "clerk"

# National Survey Results: Types of Programs

Employed in 8 types of programs:

- Independent peer support (N=70)
- Case management (N=57)
- Partial hospital/day program, inpatient or crisis (N=31)
- Vocational rehabilitation/clubhouse programs (N=23)
- Drop-in centers (N=21)
- Education/advocacy (N=15)
- Residential (N=12)
- Therapeutic recreation/socialization or psychiatric rehabilitation (N=10)

| Program | % time at agency/ on phone | % of time in the community |
|---|---|---|
| Average Across All Programs | 59% | 33% |
| Case Management | 42% | 53% |
| Partial Hospital/Day Program, Inpatient, or CRISIS | 76% | 13% |
| VR or Clubhouse | 75% | 17% |
| Therapeutic Recreation or Psych. Rehab. | 49% | 39% |
| Residential | 49% | 40% |
| Drop-In Center | 80% | 12% |
| Education/Advocacy | 65% | 19% |
| Independent Peer Support Program | 56% | 37% |
| Other/Could not be Coded | 58% | 36% |



**Salzer, M.S.**, Schwenk, E., & Brusilovskiy, E. (2010). Certified Peer Specialist Roles and Activities: Results from a National Survey. Psychiatric Services, 61, 520-523.

| Program | % Time Groups | % Time Individuals |
|---|---|---|
| Average Across All Programs | 25% | 48% |
| Case Management | 15% | 61% |
| Partial Hospital/Day Program, Inpatient, or CRISIS | 38% | 43% |
| VR or Clubhouse | 32% | 47% |
| Therapeutic Recreation or Psych. Rehab. | 36% | 44% |
| Residential | 4% | 75% |
| Drop-In Center | 41% | 37% |
| Education/Advocacy | 27% | 26% |
| Independent Peer Support Program | 22% | 51% |
| Other/Could not be Coded | 22% | 38% |



**Salzer, M.S.**, Schwenk, E., & Brusilovskiy, E. (2010). Certified Peer Specialist Roles and Activities: Results from a National Survey. Psychiatric Services, 61, 520-523.

| Please tell us how often you support your peers in… | Mean Score 1 = "Never" 5 = "Always" | Type of Support |
|---|---|---|
| peer support | 4.48 | Core Supports |
| encouraging self-determination and personal responsibility | 4.26 | |
| health and wellness | 3.87 | |
| hopelessness | 3.84 | |
| communication with providers | 3.68 | |
| illness management | 3.62 | |
| stigma in the community | 3.56 | |
| family relationships (e.g., with parents, siblings, cousins, etc.) | 2.95 | Intimacy Supports |
| spirituality/religion | 2.74 | |
| parenting | 2.14 | |
| dating | 1.74 | |
| developing friendships | 3.51 | Leisure/ Social Supports |
| leisure/recreation (e.g., exercise, hobby groups, movies) | 3.25 | |
| transportation | 3.06 | |
| citizenship (e.g., voting, volunteering, advocacy) | 2.83 | |
| education | 3.16 | Career Supports |
| employment | 2.94 | |
| developing WRAP plans | 3.04 | WRAP/ PADS |
| developing psychiatric advanced directives | 2.27 | |

**Salzer, M.S.** (2010). Certified peer specialists in the United States Behavioral Health System: An emerging workforce. Brown, L.D. & Wituk, S. (Eds.). Mental health self-help: Consumer and family initiatives (pp. 169-191). New York: Springer.

# Peer Specialist Roles in Suicide Prevention and Postvention (Salvatore, 2010)

Peer specialists can provide the following supports identified at The First National Conference for Survivors of Suicide Attempts in 2005:

1) Validating and normalizing similar experiences;
2) Increasing supportive community-based networks;
3) Communicating suicide risk/prevention information to families at hospital discharge;
4) Developing volunteer support systems;
5) Tracking patients to ensure follow-up and aftercare

In addition, peer specialists can support suicide prevention in provider or peer-led settings through activities that include:

1) Developing self-help plans for consumers coping with persistent suicidality;
2) Facilitating gatekeeper programs to recognize warning signs of suicide and interventions;
3) Operating peer-run "warm" lines for consumers coping with suicidality-related concerns;
4) Educating family members about risk factors and warning signs of suicide;
5) Facilitating peer-led psychoeducation groups on suicide prevention; and
6) Organizing suicide bereavement support groups for consumers (led by peer suicide survivors).

Salvatore, T. (October 2010). Peer specialists can prevent suicides: Properly trained peers play a vital role in regional suicide prevention effort. Behavioral Healthcare, 30(9), 31-32.

# Need for Specialized Training (Salvatore, 2010)

Additional training is needed for CPS working in suicide prevention. Suggested additional training includes:

- Basic concepts of suicide prevention and suicide loss;
- Knowing when to contact a crisis center or 9-1-1;
- Applying recovery concepts to coping after an attempt, suicide loss, or suicidal behavior;
- Developing "personal safety plans" for avoiding suicidal behavior;
- Understanding myths and stigma associated with suicide;
- Appreciating cultural/ethnic perspectives on suicide and methods of dealing with suicide loss;
- Facilitating peer-led suicide prevention/postvention groups;
- Familiarity with appropriate community resources.

Salvatore, T. (October 2010). Peer specialists can prevent suicides: Properly trained peers play a vital role in regional suicide prevention effort. Behavioral Healthcare, 30(9), 31-32.

# Barriers to Implementation of Peer Support Services

- Non-peer professional's have negative beliefs about peers
- Concerns about competence and peers being able to act professionally (e.g., maintain confidentiality)
- Non-peer professional lack of understanding of peer support theory and research
  - View peer support as inherently less helpful than "professional" services
- Lack of clarity about peer specialist roles and activities
  - Hiring problems
  - Peers assigned ancillary roles, treated as "junior staff," and given inadequate resources
- Concerns about using personal disclosure and role modeling in service delivery
- Inadequate supervision
- Concerns about dual relationships and job-induced relapse
- Limited opportunities for networking and support with other peer specialists

# Future of Certified Peer Specialists

# Growing Behavioral Healthcare Workforce

- State buy-in
  - More and more states will eventually accept peer support for Medicaid reimbursement
- CPS employment will grow
- CPS are motivated and committed and have unique perspectives that will slowly influence service and policy discussions

# Address Implementation Issues

- Human Resources
- Non-peer provider concerns
- Need for further clarification of CPS roles and activities
  - CPS could be uniquely positioned to provide supports that promote community participation
- Need for better supervision

# Career Development

- National Certification and Ethical Standards
- Organized Continuing Education Approach
- Specialized training
- College credits for CPS training and CE training
- Development of Career Ladders
  - Full acceptance of experiential knowledge as equally valuable to book knowledge
  - Connecting "CPS" positions to the non-peer career ladders (other services, supervision, policy)
- Promote connection to other behavioral health disciplines