The Power of Lived Experience

OHSU GRAND RO UNDS
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Objectives

- Recognize changes in Oregon Law related to peer services.
- Understand the experience, expertise, and contributions of peer support specialists (PSS) and peer wellness specialists (PWS) to the health care system.
- Identify ways non-peer members of health care teams can partner with peers to support the recovery and wellness of the people we care for.
Setting the Frame

• Elizabeth and Jessica will highlight current Oregon Law related to peer services.

• Meghan will share her lived experiences of mental health issues, working as a PSS and PWS, and her observations of the impact she has had on the health care system.

• Pari will share her lived experience as a resident and the benefits she has seen from consulting with Meghan on patient care.

• Throughout the presentation we will share highlights from the literature supporting the therapeutic benefit of peer services.
Health Care Reform 2011

Oregon House Bill 3650

- CCOs MUST provide member access to traditional health workers (e.g. PWS, PSS)

- Essential in meeting OHA's Triple Aim:
  - improving the lifelong health of all Oregonians
  - improving the quality, availability and reliability of care for all Oregonians
  - lowering or containing the cost of health care so that it is affordable for everyone.
• Oregon Health Authority responded by approving specific training programs across the state to qualify peer wellness specialists (80 hrs) and peer support specialists (40 hrs) as traditional health workers.

• Peer delivered services are billable through Medicaid.
Invitation...
The journey into peer wellness.....
Roots of the Mental Health Self Help Movement

- 1960s-1970s One Flew over the Cuckoo's Nest
- Groups of ex-patients share their stories
- Rise of self help concept Alcoholics Anonymous
- Recognition that many patients in the psychiatric system felt debilitated and demoralized
- Shared anger and desire to change the system
History of the Mental Health Consumer Movement

- 1845 Alleged Lunatics' Friend Society ---England
- Anti-insane Asylum Society -after the Civil War --US
- 1923 A Mind that Found Itself --Clifford Beers
- National Committee for Mental Hygiene
- 1940s Rockland State Hospital -- WANA - We Are Not Alone
- WANA becomes Fountain House --self help club
- 1970s Psychiatric Patients Liberation Movement
- Alliance for the Liberation of Mental Patients, Insane Liberation Front
Mental Patients Association
Vancouver

- People in a day treatment center were not allowed to exchange telephone numbers nor talk to each other outside treatment
- One member dies by suicide
- Formation of clandestine circulation of patients' phone list and inter-reliance among patients
- Public meeting to discuss dissatisfaction with psychiatric system
- Decision by patients to provide the services that the system had not provided
- 7 days a week drop in center, 5 cooperative residences
- Consumers in NY and Boston create similar organizations
- Mental Patients Bill of Right
Mental Patients Liberation Front

- Your Rights as a Mental Patient in Massachusetts
- Includes laws concerning commitment, voluntary and involuntary hospitalization
- Patients' civil rights
- Bill of rights
Health systems that are founded on the idea that persons receiving services are "broken" tend to be coercive and don't promote true healing.
Rise of more moderate consumer groups

- Emotions Anonymous
- Recovery Inc
- GROW

- MORE FOCUSED ON PEER SUPPORT
- Some welcomed involvement of professionals

- 1979 NAMI National Alliance for the Mentally Ill
- founded by families of individuals with serious mental illness
Consumerism moves into mainstream

- 1978, *On Our Own* by Judi Chamberlain
- Concept of consumer-run services
- "Madness Network News"
- 1976 President's Commission on Mental Health acknowledges that groups of mental health consumers are being formed across US
- 1985 First National Conference of consumers called "Alternatives"
American with Disabilities Act 1990

- Opportunities arise for more persons who have mental health challenges to obtain employment
- Provisions for training consumers to engage in legislative process
"The benefits of mutual aid are experienced by millions of people who turn to others with a similar problem to attempt to deal with their isolation, powerlessness, and alienation."

Surgeon General, C. Everett Koop, MD

- Voluntary, not mandated
- Trusting, open environment
- Ability to reach out and share experiences
- No dichotomy between helper and helpee
- Decision making in members' hands
NASMHPD Study 2006: Morbidity and Mortality among People with Serious Mental Illness

- Average age of death is 25 years earlier for persons with mental illness who are served in the public sector.
Creation of the first Peer Wellness Specialists Program

Benton County Health Department
2007
Peer support specialists (PSS) -- mainly behavioral health settings

Peer Wellness Specialists (PWS) -- mainly integrated health settings
We work too hard to recover our mental health to then just die!!!!!!!
The average age of death for a person with mental illness and substance use: 45.1 years

"Measuring Premature Mortality among Oregonians", 2008, Oregon Department of Human Services
30%-40% due to suicide and injury

60% due to medical conditions
PWS are trained to work in integrated, person-centered health home teams to help individuals learn to self-manage chronic conditions.
Why use PWS?

- Can engage with range of patients
- Cost effective
- Personal experience navigating complex systems
- Able to follow patients into community
- Prevention and Health promotion—"the other 23 hours"
Clinical Applications for using PWS

- Engaging clients who may have had traumatic past experience with mental health system
- Working with clients in community
- Helping clients navigate community/medical/social resources
- Provide advocacy for client with other medical treatment providers
- Advocacy with governmental systems
- Provide hope based on their own personal example
- Able to represent client’s perspective on treatment team
- Wellness group facilitation
- Support for self-management of complex co-occurring conditions
Cascadia's Peer Wellness Program serves:

- Out-patient clinics
- Assertive Community Treatment team (ACT)
- Forensic ACT
- Homeless Services
- Project Respond---Mobile Crisis Outreach
- Urgent walk-in, Standing Stone Resource room
- Supported Housing
- Oregon Partnership for Health Integration (OPHI)—Integrated mental and primary care
- Residential (Firefly House for Young Adults in Transition)
- Supported Education
- Jail Diversion
- Tri-county 911 Project (for individuals who frequently call 911 for health services)
Research showing efficacy of peer support in improving health outcomes


• Significant reduction in overall bodily pain

• Increased physical activity
• Increased health related quality of life

• Reduction of health problems by 30%
• Increased utilization of primary care provider

• Decreased use of emergency department
OPHI: Oregon Partnership for Health Integration
4 Year Study

- Cascadia Behavioral Healthcare
- Peer Wellness Coaches
- OUTSIDE IN provided primary care with mobile clinic
- Outpatient clinics and transitional housing
OPHI OUTCOMES

- BMI 50.89% improved
- Waist circumference 51.7%!improved
- Overall health 94.7% change
- No serious distress 42.9% change
- Attending school regularly or currently employed 50%
- Socially connected 43.3%
Meghan Caughey, MA, MFA, CPRP

Senior Director

Peer and Wellness Services

Cascadia Behavioral Healthcare

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The Power of Consulting an Expert with Lived Experience
For your reference,

- O'Donnell et al. (1995) -- 2 year outcome study reported no differences in impact of care provided by peers on hospital rates or length of stay. (no difference demonstrates that people in recovery are able to offer support that maintains admission (relapse) rates comparable to professionally trained staff.

- Clarke et al. (2000) found that when assigned to either all peer staff or non-profit consumer community teams that those under the care of peers tend to have longer community tenure before their first psychiatric hospitalization.

- Chipman, Weingarten, Stayed and Davidson (2001) compared a peer support program with traditional care and found a 50% reduction in rehospitalizations compared to the general outpatient population and only 15% of the outpatient with peer support were rehospitalized within one year.
For your reference

- Forchuk, Martin, Chanel, and Jensen (2005) in an evaluation of a model of discharge involving peer support reported that peer support used as part of the discharge process significantly reduces readmission rates and increases discharge rates.

- Min, Whitecraft, Rothman, and Saltzer (2007) found that consumers involved in a peer support program demonstrated longer community tenure and had significantly less rehospitalizations over a 3-year period.

- Finally in an evaluation of Australian peer support services Lawn, Smith and Hunter (2008) found in the first 3 months of operation providing hospital avoidance and early discharge support, more than 300 bed days were saved when peers were employed as supporters for people at this stage of recovery.
“As peer support in mental health proliferates, we must be mindful of our intention: social change. It is not about developing more effective services, but rather about creating dialogues that have influence on all of our understandings, conversations, and relationships.”

– Shery Mead, Founder of Intentional Peer Services
Thank you for listening.

How can you take part in the conversation?