Peer Support Counseling Makes Sense, Saves Cents

The group approach is not meant to replace talk therapy or medication.

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An old idea—using peers to facilitate recovery—is gaining new attention from public mental health specialists as they search for ways to help the mentally ill get care in an overstretched system and return to productivity.

Peer counseling is the foundation of Alcoholics Anonymous, Narcotics Anonymous, and similar groups that tap people during their recovery to help others get on the same path.

The counselors "can provide a powerful message of hope for people who are hopeless," said Sue Bergeson, executive vice president of the Depression and Bipolar Support Alliance. They also "stand with that individual through their journey through recovery," said Ms. Bergeson in an interview.

The DBSA believes that peer support improves recovery and is participating in a research project with Dr. Greg E. Simon, a psychiatrist at Group Health Cooperative of Puget Sound's Center for Health Studies, Seattle, to document the impact of peer support on patient outcomes compared with traditional care.

In the mental health field, people in recovery from depression, bipolar disorder, and other psychiatric conditions may offer one-on-one advice, lead mutual support groups, or staff desks at drop-in centers where they can counsel peers on finding employment and managing day-to-day living issues.

Some self-help groups have been around for decades: GROW Inc., Recovery Inc., and Schizophrenics Anonymous, for instance.

Peer support—defined partly as the sharing of experiential knowledge, skills, and social learning—was included as 1 of the 10 fundamental components of recovery in a recently released consensus statement by the Substance Abuse and Mental Health Services Administration.

Backers of peer support say it improves outcomes and reduces costs. In an overview of the field, Phyllis L. Solomon, Ph.D., a professor of social work at the University of Pennsylvania, Philadelphia, cited numerous studies showing that peer support programs improve symptoms, coping, social functioning, and medication adherence, as well as reduce hospitalizations and use of crisis services (Psychiatr. Rehabil. J. 2004;27:392-401).

Preliminary, yet-to-be-published data from a Georgia study show that peer support improved symptoms and patient functioning at half the cost of traditional care in Medicaid recipients with schizophrenia, depression, and bipolar disorder, said Larry Fricks, former director for consumer relations in the Georgia Department of Human Resources.

However, peer support is not meant to replace therapy—whether talk therapy or medication—provided by a licensed psychiatrist or psychologist.

In Georgia, for instance, where peer services are billable under Medicaid as a psychiatric rehabilitation benefit, a patient who enters the public mental health system is diagnosed by a clinician, who then can recommend peer support as one of the steps toward recovery, said Mr. Fricks, who is now director of the Appalachian Consulting Group in Cleveland, Ga.

The state will bill Medicaid $7 million this year for peer support, Mr. Fricks said in an interview. About 3,000 people are receiving peer support services in Georgia, he said. He is in recovery from bipolar disorder, and his consulting company is working with the federal government to adopt the Georgia model for use in other states.

Those seeking to become counselors in Georgia have to document that they are in recovery and must go through a certification process. About 300 people have completed that process, which includes two weeklong training modules and a written and oral exam.

Peer specialists are expected to help patients create a recovery action plan, find a job, handle employment-related issues, and learn how to use community and other support systems.

South Carolina and Hawaii have already begun peer certification programs, and seven other states are in the early stages, Mr. Fricks said.

Training is crucial, said Dr. Jana Spalding, the mental health specialist in the Broward County Sheriff's Office in Fort Lauderdale, Fla. Florida is one of the states seeking to start certification and receive Medicaid reimbursement.

"Just because you got better doesn't mean you can help other people," said Dr. Spalding in an interview. Peer counselors have to demonstrate competency, be able to establish a rapport with someone who might be psychotic, and must be nonjudgmental and knowledgeable about medications, their side effects, and community resources, she said.

Dr. Spalding's professional path to pediatrics was interrupted several times and eventually derailed by her bipolar disease. She ended up taking a job at the peer support center where she had been receiving assistance.

Now, through the sheriff's office, she and a team of psychologists work with mentally ill inmates. Dr. Spalding considers it a successful day if she can get an inmate in solitary confinement to interact with other inmates or the psychologists by playing games or watching movies, for instance.

"This is another tool," Dr. Spalding said. "It provides a lot of intangible benefits in restoring hope, expectation of recovery, and anticipation of improvement of life in general—not just symptoms going away," she said. ■

POLICY & PRACTICE

Bill Seeks Consent for Off-Label Rx

A bill in the California assembly would require physicians to get informed consent from their patients before "prescribing, administering, or furnishing" a prescription for off-label use. A failure to adhere to the requirement would be considered a violation of the Medical Practice Act, which means physicians could be charged with a crime. The California Medical Association opposes the legislation and said the existing law is enough because physicians can be held liable for not disclosing risks. The bill would require physicians to specify that a medication is not approved by the Food and Drug Administration for the use that the doctor is recommending, and that the risks are unknown and there is not a consensus on the efficacy.

Obesity Linked to 2%-3% of Claims

Obesity accounts for 2%-3% of medical claims dollars, according to a retrospective study in the March issue of the Journal of Occupational and Environmental Medicine. Researchers at Gordian Health Solutions Inc. assessed claims from January 2000 to December 2004 from 61 employers. In 2004 inflation-adjusted dollars, total claims for the study period amounted to $4.55 billion. Obesity was responsible for 2.1% of total claims for male workers ($3.55/member per month) and 2.8% for female workers ($5.71/member per month). The true tally may be higher, said the researchers, noting that their analysis excluded prescription drug costs. Given that the data show a rise in obesity-related costs with increasing age, "childhood obesity may have significant lagged effects."

IOM on Quality Improvement Groups

An Institute of Medicine committee has released a report on Medicare's Quality Improvement Organizations that describes these groups as spending too much time on reviewing beneficiary complaints and not enough on helping physicians and health care organizations to actually improve care. The panel said there are inherent conflicts when the QIO reviews complaints about organizations it needs to voluntarily participate in quality improvement efforts, and suggested that case reviews should be shifted to regional or national agencies. The 22-member IOM panel spent a year investigating the 41 organizations that are hired by Medicare to improve quality of care, address patient complaints, and review claims to ensure they meet quality benchmarks and reimbursement standards. Stephen M. Shortell, Ph.D., an IOM panel member, said the committee's main finding was that, while the quality of care has improved, "the pace of change is too slow, and gaps in quality persist." QIOs should be providing more technical assistance to physicians and hospitals, said Dr. Shortell, who is a professor of health policy and management at the University of California, Berkeley. The IOM panel said that QIO boards—which it said are dominated by physicians—should include more consumers, representatives of other health fields, and health information technology experts, and have greater accountability to the public. The American Health Quality Association, a QIO trade group, said it supported most of the recommendations, but said that the organizations should continue to review complaints and appeals because it provided "invaluable opportunities to help providers improve care for all patients." The AHQA also noted that 30 of 41 QIOs had signed a code of conduct that would make them more accountable.

Many Enrollees Happy With Part D

A new survey of Medicare beneficiaries who are receiving Part D drug benefits finds them to be largely satisfied. The survey—conducted 10 weeks into the new coverage—was paid for by America's Health Insurance Plans, and conducted by Ayres, McHenry & Associates Inc., a Republican polling firm. The poll surveyed 408 of the 5.2 million people over age 65 years who have self-enrolled in Part D, and 401 of the 6.5 million "dual eligibles," who were automatically enrolled because they had Medicaid drug coverage. Of those who self-enrolled, 66% said it had been worth the time and effort to enroll, and four-fifths (84%) said they had no problem signing up. The majority—85%-90% of both groups—said they had no problem using the new benefit. "This is a dramatic departure from the conventional wisdom about this program," said Whitfield Ayres, Ph.D., president of the polling firm. But Ron Pollack, executive director of the advocacy group Families USA, said it was not surprising that beneficiaries who went to the trouble to sign up were happy. Shockingly few have signed up, however, Mr. Pollack said. "America's seniors are clearly voting with their feet," he said.

All Groups at Risk for Poor Care

Although disparities exist in health care among various ethnic and racial groups, those gaps are small compared with the health care everyone receives and what they should be receiving, according to a report from the Rand Corporation. "Differences exist. But they pale in comparison to the chasm between where we are today and where we should be," said Dr. Steven M. Asch of the University of California, Los Angeles, the study's lead author. "These findings tell us that no one can afford to be complacent, and they underscore that the quality-of-care problem in this country is profound and systemic." The study assessed preventive services and care for 30 acute and chronic conditions that constitute the leading causes of death and disability. Overall, participants received about 55% of recommended care, despite the fact that the recommendations for the conditions involved were widely known and accepted.

—Alicia Ault