The Nelson A. Rockefeller Center at Dartmouth College

The Center for Public Policy and the Social Sciences

Policy Research Shop

PEER COUNSELING SERVICES IN VERMONT

Assessing the Efficacy of Community Mental Health and Peer Counseling in Vermont

Presented to the Vermont Senate
Committee on Health and Welfare

PRS Policy Brief 1314-11
May 20, 2014

Prepared By:

Ashneil Jain
Roshen John
Marie Plecha

This report was written by undergraduate students at Dartmouth College under the direction of professors in the Rockefeller Center. The Policy Research Shop is supported by a grant from the Fund for the Improvement of Postsecondary Education (FIPSE). The PRS reports were developed under FIPSE grant P116B100070 from the U.S. Department of Education. However, the contents of the PRS reports do not necessarily represent the policy of the U.S. Department of Education, and you should not assume endorsement by the Federal Government.

Contact:
Nelson A. Rockefeller Center, 6082 Rockefeller Hall, Dartmouth College, Hanover, NH 03755
http://rockefeller.dartmouth.edu/shop/ • Email: Ronald.G.Shaiko@Dartmouth.edu

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EXECUTIVE SUMMARY

In 2012 the Vermont Legislature passed Act 79 following the significant loss of inpatient mental health care beds from Tropical Storm Irene. Act 79 provided resources to expand the state's community-based approach to mental health care, including peer counseling services. This report provides an in-depth analysis of Vermont's community-based programs, specifically the Community Rehabilitation Treatment programs, focusing on client outcomes, peer counseling providers, costs, and policy changes from Act 79. It first assesses existing research on the effectiveness of peer counseling and community-based programs in improving mental health outcomes. Since housing stability is associated with mental health outcomes, housing programs available for Vermont residents with severe and persistent mental health conditions are examined. The report also considers the changes in peer counseling services resulting from Act 79 and services in several other states (Maine, Connecticut, and New Hampshire). The analysis highlights potential options for Vermont in improving its provision of mental health services, and peer counseling programs in particular.

1. INTRODUCTION

1.1 Defining Community-Based Peer Counseling

"Community-based peer counseling" refers to the provision of support services to mental health patients by others who have overcome psychiatric disabilities themselves.[1] These services reflect the belief that through principles of empathy and shared experiences, peer counselors can provide current patients with a sense of encouragement and hope.[2] While many peer support providers undergo training in order to administer counseling services effectively, they are not trained psychologists, therapists, or psychiatrists; rather, they often face mental health issues themselves.

The notion of "community-based programs" excludes inpatient or hospital settings in which patients live directly in a facility for a specific period of time. Peer counseling programs instead direct the focus of recovery to developing skills necessary to lead meaningful lives within a community.[3] Peer counselors are often introduced to patients in a hospital setting but become formalized after the patients are released from the hospital. Through the development of strong interpersonal relationships and a shared sense of community, peer counseling programs aim to lay the foundation for a successful recovery process.[4]

1.2 Existing Research on Peer Counseling

Both quantitative and qualitative studies have examined the effectiveness of peer counseling services for individuals with persistent mental health illnesses. Overall, peer counseling services, which include peer specialist services, peer-run or peer-operated services, and mutual-help groups, have been shown to yield positive clinical and personal

outcomes for patients, despite some challenges in defining roles for counselors.[5] Quantitative indicators indicate that these programs result in lower re-hospitalization rates and higher quality of life measures. For example, Lawn et al. (2008) analyze an early discharge and hospital avoidance support program provided by peers, and find that the service saved 300 bed days and the associated costs.[6] Additionally, Felton et al. provide evidence for greater gains among several quality-of-life measures and fewer major life problems in patients receiving peer specialist services than in those treated by other providers.[7]

Qualitative research suggests that peer counseling fosters feelings of understanding, trust, and satisfaction during treatment. A study of intensive case-management teams that included peer providers find that participants receiving peer-based services report more positive provider relationship qualities than participants in the control condition.[8] Qualitative studies have also reported enhanced recovery attitudes, more outspokenness about pursuing personal goals, and increased self-esteem in individuals and groups receiving peer counseling.[9]

For individuals administering services, peer counseling may generate some negative and positive outcomes. Providers, who often face mental illnesses themselves, receive the benefits of self-efficacy from helping others, increased self-knowledge from communication with others with shared experiences, and an increased sense of perseverance.[10] However, individuals providing peer counseling have reported challenges including difficulty in transitioning from “patient” to “staff/provider,” boundary issues with patients, and role ambiguity as a provider of support.[11] While peer counseling appears to impart benefits to providers as well as patients, the outcomes prove more mixed.

Peer counseling appears more effective in rural areas, which has unique implications for Vermont. Rural America faces a higher proportion of people at risk for mental health issues and suicide than urban and suburban areas. A cultural emphasis on self-reliance in rural areas may also lead individuals to attach a negative stigma with seeking mental health services.[12] Provision of highly specialized mental health services is often inadequate or inaccessible in these areas, further preventing care from being administered effectively.[13] Peer counseling services, by supplementing professional services that rural patients are able to access, present significant potential to facilitate the recovery process and counter the stigma associated with seeking help.

Overall, evidence suggests that peer counseling services provide numerous positive outcomes. The services often result in reduced re-admission rates, improved scores on quality of life measures, and enhanced recovery attitudes among mental health patients.[14]

2. COMMUNITY-BASED CARE IN VERMONT

Community-based care has become an increasingly important feature of the Vermont mental health care system in recent years. After Tropical Storm Irene flooded the State Hospital in 2011, fewer patients were able to utilize psychiatric inpatient services. Without access to these services, many mental health patients relied on community-based programs, completely forgoing the inpatient hospital setting. A study conducted by the Department of Mental Health showed a decrease in the number of community based program enrollees utilizing inpatient psychiatric services from 47 patients per day before Tropical Storm Irene to 29 patients per day after the storm.[15] The new emphasis on community based mental health care, coupled with changes allowing services once paid for by funds at the state hospital to be matched in large part with federal Medicaid and Medicare dollars, has allowed community based care the chance to expand and improve.[16] Since community mental health providers mostly implement peer counseling, the system's features and outcomes are important to examine.

2.1 Scope of CRT Programs

The state's community based mental health care is organized around a network of 10 non-profit service providers named Designated Agencies by the Department of Mental Health. Each agency is responsible for ensuring the availability, coordination, and monitoring of needed services and outcomes within their geographic region. Each Designated Agency provides a Vermont Community Rehabilitation and Treatment (CRT) program to assist adults diagnosed with persisting mental illness. There is a CRT program in Addison (CRT code CSAC), Bennington (UCS), Chittenden (HC), Lamoille (LCMH), "Northeast" which includes Newport and St. Johnsbury (NKHS), "Northwest" which includes St. Albans (NCSS), Orange (CMC), Rutland (RMHS), "Southeast" which includes Bellows Falls, Brattleboro, Springfield, and White River Junction (HCRS), and Washington (WCMH).[17]

CRTs provide several core services. They provide emergency care and crisis stabilization, as well as general clinical assessments, which involve assessment of both individuals and their support systems in their strength, needs, and severity of disability. They are also involved in the planning and coordination of services for patients and their families, including individual, group and family therapy, as well as other supportive programs such as counseling, assistance for daily living, and relevant community activities. They are involved in the evaluation of the need for medication, monitoring health status, and consulting with primary care providers.

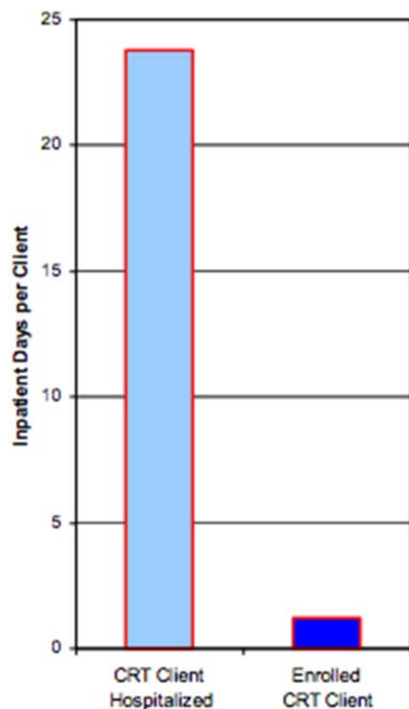
Designated Agencies also provide additional services where resource capacity exists. Employment services are involved with employment assessment, job development and training, and ongoing support to maintain employment. Many also offer housing and home supports, which includes assisted living, more closely observed staffed living, and group living. Designated Agencies are often also able to refer patients to specialty

services if need be. Through this comprehensive list of community based connections and resources, CRTs are designed to keep mental health patients engaged in their community rather than remaining in the expensive, life-disrupting emergency room and hospital settings.[18]

2.2 Inpatient Psychiatric Utilization

CRT programs are meant to keep patients from having to resort to disruptive and expensive formal inpatient psychiatric services. From October 2012 to December 2012, 139 CRT clients received inpatient psychiatric treatment.[19] Figure 1 shows that these individuals had an average of 24 days of hospitalization. Considering all CRT clients (both those who received inpatient services and those who did not), this translates to an average hospital stay of 2 days per client. The utilization figures are similar for the period from July to September 2012. Whether the rates are high in absolute terms is difficult to determine. CRT programs appear to keep the majority of their clients out of inpatient

Figure 1. Inpatient Psychiatric Utilization by Community Rehabilitation & Treatment (CRT) Clients, Vermont, October-December 2012



Source: John Pandiani and Emma Harrigan. (2013). *Inpatient psychiatric utilization by CRT service recipients during October-December 2012*. Agency of Human Services, Department of Mental Health. Available at: http://mentalhealth.vermont.gov/sites/dmh/files/pip/DMH-PIP_Mar_29_2013.pdf.

psychiatric care. However, there is clearly room for improvement in mental health care among some Vermont residents. A small number of clients account for the

hospitalizations. Additionally, substantial differences exist in inpatient utilization among the various CRT programs. Chittenden and Newport and St. Johnsbury Designated Agencies had average inpatient days per client of 34 days and 33 days, respectively.[20] By contrast, Washington (WCMH) clients averaged less than 20 days.

2.3 Avoidable Emergency Room Utilization

Emergency room use for physical health conditions—not only inpatient psychiatric stays—is also higher among CRT program clients. Appendix Figure 1 shows that between 14 and 16 percent of CRT clients had potentially avoidable emergency room visits from 2003 to 2011. The rate was approximately 3.5 times higher than the rate for the general Vermont adult population. Improving mental health outcomes may therefore have potential benefits beyond reduced inpatient psychiatric care utilization. In general, CRT programs seek to stabilize crises and work with primary care providers to best monitor the health and wellbeing of the clients. The hope is that this more individualized community approach will prevent the need for more costly formal emergency measures.

2.4 Employment Rates

The ability to find and maintain employment is an important goal for nearly all CRT program clients. Data provided by the Department of Labor and the Department of Mental Health showed that employment rates for CRT clients had remained consistently 21-23 percent from FY2000 to FY2008. The rate decreased to 20 percent in FY2009, and decreased further to 15 percent in FY2012 and FY2013 (see Appendix Figure 2). This decrease could be due in part to a difficult job market overall, and the fact that CRT programs are receiving more clients, many of whom may have been off the radar otherwise and may have more severe types of mental illness. However, despite this overall downward trend, rates increased from FY2012 and FY2013 in five of the ten of the regions for which there is a Designated Agency. NCSS showed a 64 percent increase (from 8 percent to 13 percent) and HCRS showed a 40 percent increase (from 8 percent to 11 percent). The greatest decrease was exhibited by Bennington (USC), which decreased its rate by 13 percent (ten percent to eight percent) (see Appendix Figure 3).[21]

2.5 Effectiveness of Employment Services

Perhaps a more telling metric of CRT effectiveness is the employment of CRT clients by the amount of employment services received. During FY2012, 66 percent of clients did not receive employment services. 14 percent received less than six employment services, and 205 received six or more (see Appendix Figure 3). Variation of employment rates did depend on the amount of employment services utilized. 11 percent of clients receiving no services obtained employment, while 27 percent of those receiving less than six services, and 40 percent of those receiving more than six services, obtained employment. Variation also existed across the Designated Agencies. Twenty percent of clients receiving no employment services obtained employment in LCMH, while only one percent of those

not receiving services were able to obtain employment in CMC. Fifty-four percent of HC clients were able to obtain employment with less than six services, while only eight percent of USC clients were able to do the same with the same amount of service use. For Washington (WCMH), 63 percent clients receiving six or more services obtained employment, while only 21 percent in HCRS were able to do the same with six or more services (see Appendix Figure 4).[22] While the amount of utilized employment undoubtedly plays a role in a client's ability to obtain employment, the variations among the various CRT programs across the state are patterns that should not be ignored.

2.6 Satisfaction with Services

While effectiveness and utilization numbers are useful, it is important that the experiences of enrollees of CRT programs are meeting their individual needs and goals. It is for these individuals that the programs exist in the first place. The Department of Mental Health has developed and released the 2012 consumer satisfaction survey, which examines the subjective evaluations of the clients served during the past year. It examined overall experience, service, respect, access, autonomy, and outcomes. Statewide in Vermont, 82 percent of respondents rated the programs favorably overall. Service, respect, access and autonomy ranged from 82-85 percent favorable, while the outcomes dimension was only 71 percent favorable. The most favorably rated items were focused on staff and services. Statements such as "staff treated me with respect" and "staff members I work with are competent and knowledgeable" were rated favorably 88 to 90 percent of the time. The least favorably rated items were related to outcomes of treatment. "I feel I belong in my school community" and "my symptoms are not bothering me as much" were rated favorably 57 percent to 68 percent of the time.[23] The Vermont Department of Mental Health also collects data on social connectedness of CRT clients (see Appendix Figure 4).

3. VERMONT PEER SERVICES

Peer mental health services are a community-based initiative and have developed substantially in Vermont in recent years. Historically, peer services were run from a few major independent organizations, including Vermont Psychiatric Survivors, Another Way, and NAMI-Vermont. Tropical Storm Irene brought about an increased demand for community based mental health care for the state, so over the past two years, Act 79 has expanded the availability of services provided by peers such as community outreach, support groups, local peer-run initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community recovery settings, and family-to-family peer support for people with a family member with severe mental illness.[24] This effort has resulted in the establishment of new peer centered organizations, such as Alyssum in Rochester, the improvement and expansion of existing peer centered groups, as well as the addition of peer-oriented programming in some of the ten Designated Agencies. Several of these organizations are summarized in Figure 2.

Figure 2. List of Major Peer Counseling Program Providers

Peer Organization	Services Provided	Utilization
Another Way	Community center providing outreach, community and network building, support groups, service linkages, employment supports.	Serves an average of 100 unduplicated individuals each month.
Alyssum	2-bed program providing crisis respite and hospital diversion.	Serves approximately 6 unduplicated individuals per month.
Vermont Psychiatric Survivors	Statewide organization providing community outreach, support groups, local peer-run micro-initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings.	Provides a per month average of: -150 outreach visits in the community for support and advocacy; -100 warm-line support calls; -65 calls for information or referral.
NAMI-VT	Statewide organization providing support groups, educational and advocacy groups.	Serves an average of 232 unduplicated individuals per month

(Source: Figure 2 compiled by authors.)

3.1 Need for Peer Services

The community outreach, support groups, advocacy, hospital-to-community transition support, and other programs administered through peer services offer something different from traditional hospital treatment or even community based mental health care, and for this reason have become increasingly popular. Individuals with mental health concerns are often difficult to interact with. Many are unable to communicate their concerns, and will respond to a provider's questions with broken English, fragments of ideas, and gibberish. Some may actively try to manipulate the provider, making attempts at progress counterproductive. Primary care providers, social workers, case managers, and other traditionally trained professionals often not have the time, money, or capability to successfully sort through these difficulties, understand exactly what the patient wants and needs from their services, and to provide exactly that, in a way that will work for the patient. Peer services are unique because they are run by individuals with mental health concerns who have successfully worked within the system and found stability. They are better able to sort through the gibberish and understand the client wants, and present those wants to the provider. Peers are often better positioned to follow up very regularly with the client – sometimes meeting with clients every day for many successive weeks. Over time, peers can develop a more true sense of the individual's goals and needs. With the deep understanding of what the road to recovery entails, they are able to offer relevant support, and provide connections to health and community services that will provide the recovery tools he or she desires the most. This highly specific, individualized approach to

recovery can better allow clients to own their own recovery process, and address concerns in an understanding, personal setting before they reach the crisis level.[25]

For example, the Howard Center, the Designated Agency of Chittenden County, has recently developed a mobile crisis response and support initiative, START, which is staffed by people who have battled mental illness and found stability. Dr. Sandra Steingard, director of the Howard Center, explains, "So if someone is hearing a lot of voices and doesn't know how to manage or doesn't know whether there will ever be a side, to sit with another person who has gone through this and has been able to weather the storm and pull his life together and shows it, it's better than words. It's a really powerful thing!" Steingard credits the START program with helping clients avoid hospitalization. [26]

3.2 Effectiveness of Peer Services

While collection of quantitative data from peer services is currently in its early stages, qualitative accounts have shown peer services to achieve a level of effectiveness. Vermont Psychiatric Survivors evaluates its programs by regularly accessing its clients on a one-to-five point scale: one meaning that the client has no hope in his or her future, and is unable to use his or her time constructively due to the mental illness, and five meaning that the client is feels hope, is actively engaging in his or her personal situation, and is able to use time in a constructive way. [27]

Vermont Psychiatric Survivor Support Specialist Karen Lorentzon explained that clients are typically able to move up the scale. Substantial improvements are made after consistent visits of about 12 weeks on average. Of course there is always the risk of moving back down the scale after initial improvement, and it is during those times that the personal, understanding approach taken by peer services proves most beneficial. Peers know fully well that the road to recovery is not a straight path, and are able to listen to the client's needs, support the client, and possibly connect the client with appropriate evidence and/or experience based resources.

According to Lorentzon, the greatest hindrance to the effectiveness of Vermont Psychiatric Survivors and organizations like it is the difficulty of marketing to the community. Many do not trust or see the value in the idea of "crazy people helping crazy people." Marketing this service and similar new initiatives to all the stakeholders and players affecting mental health is difficult, and they are still trying to figure out how best to do it. Otherwise, primary care providers, social workers, correctional workers, and others who do work with peer services understand the value in such a program, and are regularly utilizing it.[28]

3.3 Housing Services and Mental Health Care

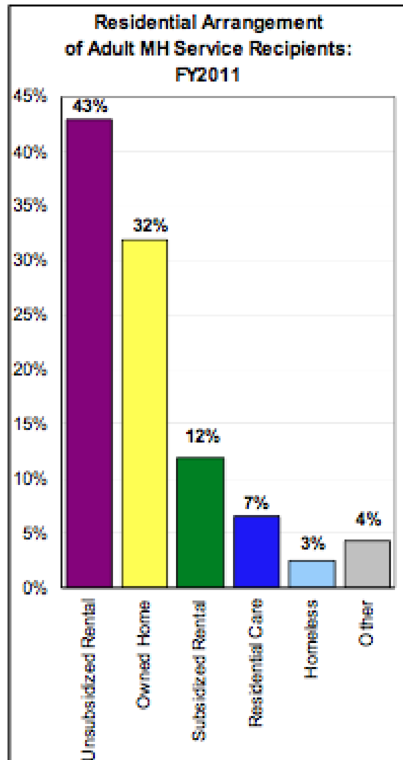
Housing is an essential component of mental health treatment programs in Vermont, for both those treated through the peer-counseling network and for mental health patients generally. While the provision of housing is not required for all mental health patients, such as individuals in outpatient or support group programs, it is often necessary for patients with severe and persistent mental illnesses. Moreover, providing adequate housing for mental health patients has emerged on the Vermont policy agenda in the last decade. In 2007, a NAMI-Vermont survey of mental health providers, patients, and family members found housing to be a major area of unmet need, with 45 percent of patients and family members reporting difficulty in obtaining or keeping their housing.[29] Respondents of the survey cited obtaining affordable housing as a top priority for mental health care reform in the state. A lack of government funding for housing assistance programs resulted in a high incidence of homelessness among individuals facing mental illness.[30]

Prior to 2012, housing assistance programs were relatively minimal. In the fiscal year 2011, the Vermont Mental Health Performance Indicator Project analyzed the residential situations of adults in both Community Rehabilitation and Treatment Programs and in Adult Mental Health Outpatient Programs.[31] The most common residential situation was "unsubsidized rental" (43 percent), while only 12 percent of mental health care recipients were categorized as "subsidized rental."[32] Three percent of recipients were categorized as "homeless." The findings of the analysis are summarized in Figure 2.

In January 2012, Governor Peter Shumlin's Plan for Mental Health established $600,000 for housing subsidies to help ensure stable housing for individuals with mental health conditions.[33] These funds, under the direction of the Vermont Department of Mental Health, aim to provide up to 100 housing vouchers annually, depending on individuals' needs and income. The vouchers and other types of subsidies are provided as much as possible using the "housing first" model, meaning that patients receive assistance without pre-qualification or agreement to accept certain services.[34] In certain cases, however, individuals are required to accept provider services, ranging from minimal case management to full wrap-around plans, in order to receive housing assistance.[35]

This increase in funding for housing subsidies, along with the Vermont Legislature's passing of Act 79 in 2012, has resulted in the expansion of housing options and assistance throughout the state.[36] Act 79 aimed to enhance Vermont's community mental health system by assisting those receiving treatment directly within their communities. As a result, expanded housing options have included transitional beds through intensive

Figure 3. Residential Arrangement of Adult Mental Health Service Recipients in Vermont, FY 2011



Source: John Pandiani and Sheila Leno. (2012). "Residential Arrangement of Adult Mental Health Service Recipients by Vermont County." Vermont Mental Health Performance Indicator Project. Retrieved from: http://mentalhealth.vermont.gov/sites/dmh/files/pip/DMH-PIP_May_18_2012.pdf

recovery programs, supportive housing units to assist people in individual apartments, and specific wraparound programs for high-needs mental health patients.[37] These programs have enabled high-needs patients to reside in a stable community setting, rather than remaining hospitalized in inpatient programs. As a result of these programs, nearly all of the patients living in the Vermont State Hospital at the time of Hurricane Irene have now received housing and community support as necessary.[38]

Additionally, the Vermont DMH and the Vermont State Housing Authority implemented the Housing Subsidy and Care Program in 2012 under Act 79, with the goal of reducing homelessness among those suffering from mental health conditions.[39] As of January 2013, the program had succeeded in housing 94 individuals who were homeless, mentally ill, and at risk of requiring an acute care bed. The individuals participating in the program demonstrated improvement in eight out of nine self-sufficiency outcome measures, representing another success of the program.[40] This includes improvements in community involvement, income, and substance-abuse outcome measures.

Overall, Vermont has made significant progress in the provision of adequate housing for mental health patients in the last several years; however, some issues remain apparent. In order to apply for a state housing voucher, patients must submit a 210A form, which must be signed off by psychiatrists or designated mental health agencies.[41] Many patients in Vermont, however, do not have access to a psychiatrist, and thus cannot obtain a voucher. Moreover, many mentally ill patients are also homeless and cannot sign up for vouchers without a home address.[42] In some cases, homeless patients are assured housing by a designated mental health agency, but are subsequently informed that they must participate in certain, potentially unwanted treatment programs in order to retain the housing arrangements.[43] In summary, despite significant recent progress in Vermont's housing voucher program, the system remains inadequate or inaccessible for certain mental health patients in the state.

4. IMPLEMENTATION OF ACT 79

The goal of Act 79 is to substantially strengthen the quality of mental health services within Vermont. While the Act includes a plethora of unique and differentiable provisions which span issues such as inpatient capacity and sustainability, an important focus on the act is on establishing significant peer service support from the state and Department of Mental Health (DMH). The purpose of Act 79 is to create a fully-functioning and integrated system of mental health that are shaped by the concepts of recovery, communal living, adequate supports and least restrictive care. Implementation of the act will be quite difficult given its ambition and scope, further compounded by an already stressed system due to the closure of the Vermont State hospital and a long term trend of budgetary cutbacks.[44]

4.1 Services Offered by Act 79

Act 79 begins by identifying peer services as a separate category of mental health treatment, finally differentiating it from regular community-based programs in Vermont. Then, it provides the Department of Mental Health (DMH) in Vermont with $1 million in funding for the expansion of peer counselling services. Specifically, peer support programs have expanded to include the development of a 24/7 warm line, outreach services, and crisis beds, specified in the legislation. Funding has also allowed peers to work within some designated agencies to provide supports to patients awaiting psychiatric hospitalization in emergency rooms of general hospitals and to individuals seen by crisis services[45].

Over the past year, DMH has expanded the availability of other services provided by peers. These services include but are not limited to: community outreach, support groups, local peer-run initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings. DMH also funds family-to-family peer support for people who have a family member with severe mental illness. Finally, DMH is also piloting the use of individual recovery

outcomes tools at contracted peer-run programs through a federal Mental Health Transformation grant.[46]

4.2 Outcomes of Act 79

Act 79 has made an immediate impact on the availability of services in important peer counseling locations. There has been a marked increase in peer services with the advent of the Wellness Center, Alyssum, DMH Patient Rep., Another Way, and NAMI Peer connections. However, support ought to be provided to expand the patient representative role and by providing peer field workers in the Northeast Kingdom and Bennington areas who are currently lacking significant infrastructure.[47]

Act 79 also requires less law-enforcement intervention for people undergoing mental health crisis and favors a mobile crisis outreach approach run by the peer community. Mobile teams stand on alert across the state and can be sought by family or friends of the mental health patient who is undergoing a crisis and needs an intervention. Peers have also joined some of these teams and/or perform outreach through DMH grant initiatives, providing support in homes and in emergency rooms. Mental health crisis teams performed nearly 2000 face-to-face interventions statewide in the first three months of 2013.[48]

Several peer-specific initiatives in Vermont have progressed. The capacity and infrastructure grants to peer organizations is now complete. New peer outreach services were funded in St. Johnsbury and Rutland. The peer workforce development program through Vermont Center of Independent Living has been established. Two programs are currently collecting National Outcome Measures (NOMS) and the Peer-Operated Protocol (POP), and outcome data will be available in the coming months. Additionally, the Statewide Warmline began operations in Spring 2013.

Ultimately, the implementation of Act 79 has gone smoothly, but there is room for improvement in the mental health care environment too. The final section of the report addresses several options for achieving further progress.

5. PEER COUNSELING IN OTHER STATES

This section compares peer counseling and mental health services in three New England states with the goal of identifying successful care approaches. It focuses on National Alliance on Mental Health (NAMI) state ratings and reports, which provide a consistent benchmark.

5.1 Maine

NAMI rates Maine as slightly above the national average in providing peer counseling services. However, the state's ability to provide these services, and mental health services

in general, in recent years has been hindered by cuts to Medicaid and mental health services funding. The state nevertheless continues to utilize a national, long-term grant to institute "one-stop shops" or medical homes for consumers integrating mental health, substance abuse, and primary health care. Maine's efforts to ingrate these areas of care includes a "no wrong door" policy that simplifies billing and provides competency training to provides regarding co-occurring disorders. While Maine has a licensing program for peer counselors, standardization has not been successful according to NAMI.[49]

An additional area of concern in Maine's mental health care system is the high proportion of individuals in the criminal justice system with mental health care needs. Over 50 percent of individuals incarcerated in the state's prisons have experienced mental health issues, forcing the state to collaborate with the criminal justice system more.[50] This led to the creation of a Police Crisis Intervention Team (CIT), which now operates statewide in conjunction with the one-stop shops.[51] Ultimately, Maine has demonstrated its ability as a state to innovate in mental health care, combining peer counseling, substance abuse, and primary care. The state's difficulties in providing sufficient health care services in recent years highlight the need for adequate state funding and continued evaluation by the state's DHHS.

5.2 Connecticut

NAMI rates Connecticut's peer services program as tied with Vermont for the most effective services in the nation.[52] Along with Vermont, Connecticut has the best parity laws in the nation, covering an expansive range of mental health disorders without disparity in cost-sharing, small group or other cost increasing exemptions. Both states' laws also apply to individual health policies as well as group plans. Additionally, Connecticut is a leader in the mental health space because of its culture of constant innovation, according to NAMI. Its largest psychiatric facility offers an orientation class that is taught by consumers who are hospitalized at the facility, which has had significant returns to quality. Furthermore, dollars generated from the criminal justice system are reinvested into community and peer based services such as housing for ex-offenders, jail diversion and mental health services. Also, Connecticut demonstrates that a partnership with a non-profit university like Yale can inform its programming, strategic plan and federal grant initiatives. The state has leveraged this connection to become one of the highest spenders per person on mental health. Vermont ought to leverage such partnerships with state colleges to gain similar advantages. Finally, another innovative program Connecticut has started is the electronic information Recovery Management System, which could connect all of their mental health, substance abuse, and criminal justice information to provide the state with a comprehensive apparatus of data moving forward, which could enhance its position as a leader in mental health services.[53]

5.3 New Hampshire

NAMI rates New Hampshire as far below the national average in peer-run mental health services. New Hampshire can be described as a state with a lot of strong pilot programs but not a strong state-wide mental health program. For example, a health recovery program, which includes mental health, developed at Dartmouth College served several hundred people in recent years with striking improvements in health outcomes, but has not been duplicated across the state.[54] Another Dartmouth College program, supported employment, only reaches around 700 people, even though it is incredibly cost effective. One of New Hampshire's major contribution to the mental health apparatus across the country is the In Shape program, which uses health trainers to help individuals with mental illness to address metabolic syndrome. New Hampshire's major concern remains the lack of hospital beds for acute patients. According to NAMI in 2009, the state had an urgent need to expand both voluntary commitment and involuntary commitment beds.[55]

6. FUTURE OPTIONS AND CONCLUSION

Several options exist for Vermont to strengthen its peer counseling apparatus. Based on the report's assessment of peer counseling and housing for residents with mental health needs, the Act 79 implementation, and the case studies, seven options are examined below.

1) *Create a data analysis collection system for CRT programs*

The Department of Mental Health keeps high-quality quantitative and qualitative data on the effectiveness of Vermont's ten Designated Agencies and their CRT programs. However, many organizations providing peer services are in the early stages of collecting and assessing such data. In order to further investigate and determine the value of peer services, a system of collecting and analysis of both quantitative and qualitative data on a regular basis might be established. Data on peer-centered initiatives might be collected and analyzed for the new peer initiatives in Designated Agencies and the separate peer-focused organizations. Due to the personal, friendship-centered nature of peer services, collection of quantitative data such as hospital utilization may seem out of place in some instances. However, data such as consumer satisfaction, quality of life, individual case studies, and other more holistic reports are likely to be particularly useful in further investigating the strengths and weaknesses of the peer-centered approach.

2) *Provide a training apparatus for peer counselors*

As peer counseling services expand, the need for quality control on peer counselors will increase, especially since the resources of existing providers are already limited. As noted in the previous section, Maine has a certification program, but the lack of standardization in the certification presents a challenge. Vermont's DMH may improve the quality and

reputation of its peer counseling services by formally ensuring reasonable training and supervision of peer counselors, since they are not currently trained in a formal capacity. The Act 79 implementation recommendations by Behavioral Health Policy Collaborative also emphasize training of peer counselors.[56] Vermont might look to Maine for initial guidance about certification procedures. DMH can also explore potential reimbursement for these services under Medicaid.

3) *Further increase government funding for housing subsidies for mental health patients*

Despite the expansion of subsidies through the Governor's Plan for Mental Health and Act 79, some patients still lack access to adequate government assistance for housing. Allocating additional government funding to these programs may help expand the overall scope and accessibility of the system.

4) *Simplify the process of obtaining a housing voucher, especially for homeless patients*

The current system appears burdensome for individuals lacking a home address or access to a psychiatrist, since some patients' conditions may preclude them from fulfilling these requirements easily. Simplifying the process by eliminating some of these stipulations may make housing more accessible for individuals in the most vulnerable stages of recovery.

5) *Provide subsidies using the "housing first" model as much as possible*

Programs can aim to provide housing assistance without pre-qualification or agreement to accept certain services. The "housing first" model prioritizes the needs and potential constraints of individuals suffering from illness, further facilitating an accessible subsidy system and promoting a stable recovery process.

6) *DMH can partner with a nonprofit support center*

As peer services expand due to Act 79 and other pending legislation, new development and infrastructure capacity will be needed by provider organizations. Currently, peer counseling organizations feel immense pressure to mobilize rapidly and respond to Act 79's expectations for development of new peer services. Yet, as these organizations limited in their capabilities spanning from programmatic options, infrastructure and staffing, they are unlikely to be able to take on large-scale projects envisioned by Act 79. Instead of letting these groups struggle through the development of infrastructure necessary to implement these new services, DMH might partner with a nonprofit support center to work with the State's leadership for a certain period of time to develop the skills needed for program development. This could include activities such as but not limited to governance, financing, evaluation and grant writing.[57]

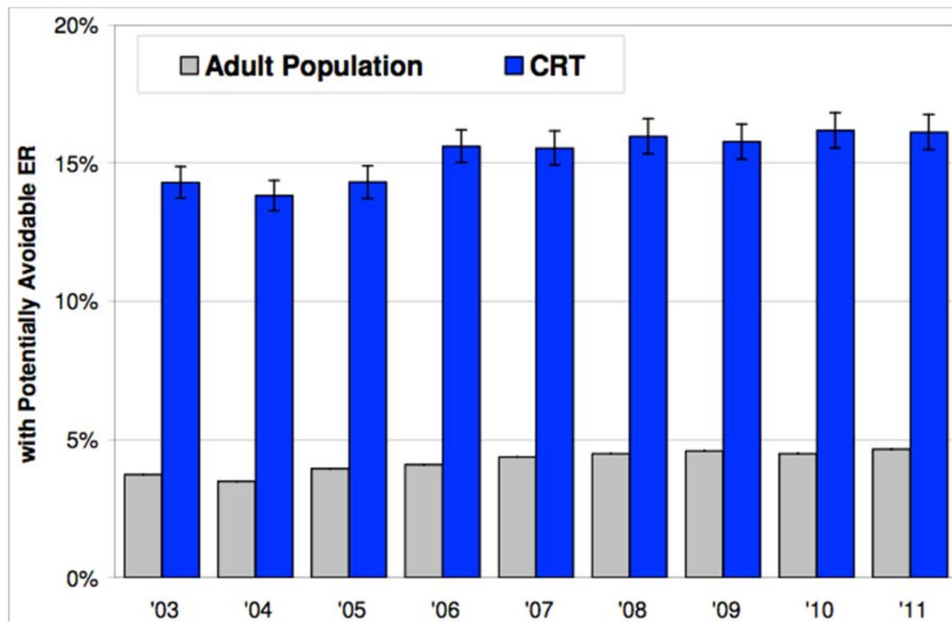
7) DMH can provide incentives to meet grant funding levels

DMH might consider further utilizing performance metrics in contracts and grants to provide incentives to providers to meet certain outcomes. It could do this by allotting a small fraction (two-to-eight percent) of Act 79 funding. In the current conditions of public mental health systems, it is important that contracted providers remain accountable to health outcomes. However, the accountability must be based on objective metrics that depend on data and evidence. Many states, such as Connecticut, have established these systems for community based and specifically peer counseling which Vermont might emulate. Some examples of metrics used by other states include number of people living in an integrated community arrangement or number of people with new criminal justice involvement within six months of the expansion pursuant to Act 79.[58]

Overall, Vermont's mental health care system has improved notably since Hurricane Irene forced the Vermont State Hospital to shut down in 2011. Act 79 provided an important springboard to strengthen peer services and mental health outcomes in the state. While Vermont still has room for improvement in fully establishing the peer services apparatus throughout the state, several feasible options exist to achieve such improvement.

7. APPENDICES

Appendix Figure 1. Potentially Avoidable Emergency Room Utilization: Vermont General Population and Community Rehabilitation & Treatment (CRT) Clients, 2003-2011



Source: Pandiani, John, and Harrigan, Emma. (2013). *CRT clients with potentially avoidable emergency room visits, 2003-2011*. Agency of Human Services, Department of Mental Health. Available at: http://mentalhealth.vermont.gov/sites/dmh/files/pip/DMH-PIP_April_19_2013.pdf.

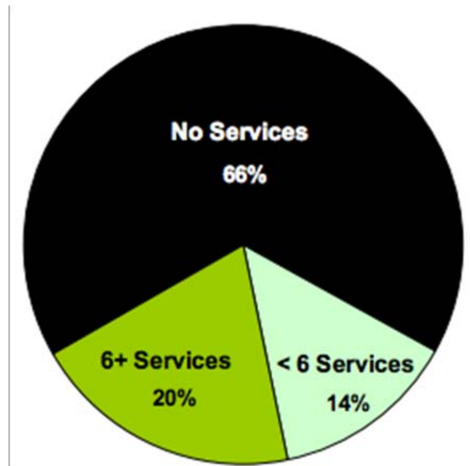
Appendix Figure 2. Employment Rates Among CRT Clients, Vermont, 2000-2013

Statewide CRT Employment Rates and Average Earnings
First Quarter of each Fiscal Year 2000 - 2013

	First Quarter (July - September) of Fiscal Year													
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
% Employed	21	22	23	22	21	22	21	21	21	20	16	15	15	15
$ / Employed Client	1,782	1,912	2,186	2,051	2,030	2,110	2,223	2,405	2,346	2,282	2,295	2,283	2,256	2,379

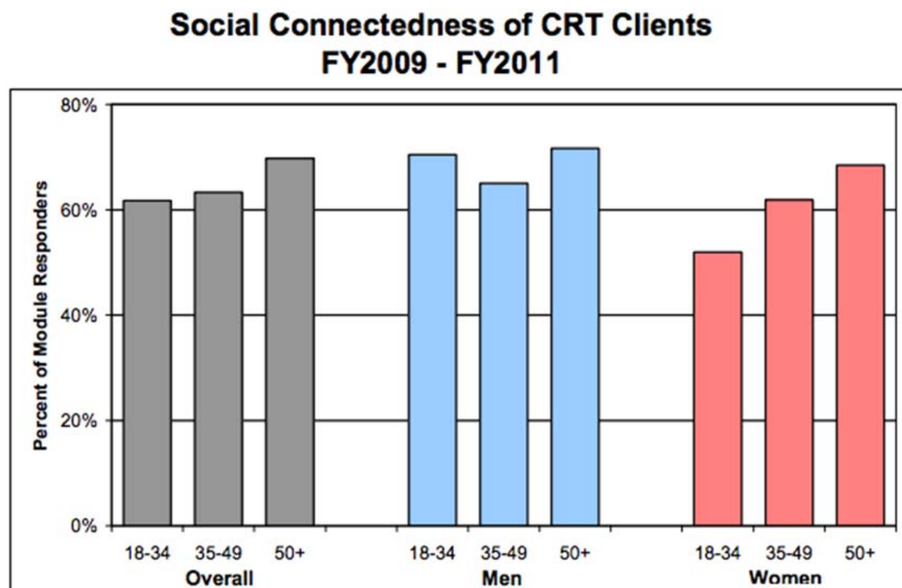
Source: Pandiani, John, & Leno, Sheila. Agency of Human Services, Department of Mental Health. (2013). *Employment of CRT clients: First quarter of fiscal years 2000-2013*. Retrieved from website: http://mentalhealth.vermont.gov/sites/dmh/files/pip/DMH-PIP_Mar_01_2013.pdf

Appendix Figure 3. Number of Employment Services Received by CRT Clients, Vermont, FY2012



Source: Pandiani, John, & Leno, Sheila. Agency of Human Services, Department of Mental Health. (2013). *Employment of CRT clients: First quarter of fiscal years 2000-2013*. Retrieved from website: http://mentalhealth.vermont.gov/sites/dmh/files/pip/DMH-PIP_Mar_01_2013.pdf

Appendix Figure 4. Social Connectedness of CRT Clients, Vermont



Source: Pandiani, John, & Harrigan, Emma. Agency of Human Services, Department of Mental Health. (2012). *Social connectedness of adults with serious mental illness during fy2009 - 2011* . Retrieved from website: http://mentalhealth.vermont.gov/sites/dmh/files/pip/DMH-PIP_July_27_2012.pdf

Appendix 5. Enhanced Programming by Designated Agency

Designated Agency	Enhanced programming
Clara Martin Center (Orange County)	Mobile emergency/crisis response, mobile outreach, care coordination, adult outpatient program (AOP) case management, hospital diversion/step down. Enhancements will include creation of crisis program with 2 beds for hospital step-down or diversion
Counseling Services of Addison County (Addison County)	Mobile emergency/crisis response, peer supports in emergency rooms and community, case management for adult outpatient program (AOP), additional staffing for existing crisis and residential beds to treat higher acuity, week-end drop-in support center
Health Care and Rehabilitative Services (Windham & Windsor Counties)	Enhancement of crisis care centers to improve access and divert emergency room use, expansion of walk-in clinics for adult outpatient (non-CRT), increased mobile support capacity, AOP case management, expansion of police social worker program
HowardCenter (Chittenden County)	Increased CRT case management, enhanced AOP and case management, development of peer staffing supports for 3 apartments (6 beds), Peer-staffed mobile crisis response and support (START)
Lamoille Community Connections (Lamoille County)	Enhanced AOP services (case management, vocational), mobile crisis team, mobile outreach for pre-crisis support, peer-run warm line and other community supports, 2-bed crisis program
Northeast Kingdom Human Services (Essex, Orleans, Caledonia Counties)	Enhanced emergency services, mobile outreach, and first intercept (e.g. police); AOP case management
Northwest Counseling and Support Services (Franklin and Grand Isle Counties)	Establish Mobile Crisis Team; case management for AOP; Enhance crisis bed into Crisis Care Center; expand peer outreach services
Rutland Mental Health Services (Rutland County)	Establish mobile crisis team; 2-bed expansion to crisis stabilization program;
United Counseling Services (Bennington County)	Develop mobile crisis program; increase peer support groups and peer warm line; enhanced AOP, including case management
Washington County Mental Health (Washington County)	Enhanced emergency services with nurse practitioner and street interventionist; develop emergency room diversion center, case management, and emergency respite care for AOP;

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