Access to Primary Care: Are Mental Health Peers Effective in Helping Patients After a Psychiatric Emergency?

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ABSTRACT

Introduction: Premature death in people with serious mental illness can be due to untreated medical conditions. There is need for community resources to support people with mental illness and assist with connections to medical care.

Methods: Study participants (N=175) were recruited from a psychiatric emergency room as part of a randomized trial examining access to primary care after a psychiatric crisis. The intervention group worked with primary care navigators, versus the control group who received usual care. All patients were offered mental health peers and were followed for 1 year.

Results: Patients with mental health peers were statistically more likely to follow through with primary care, and patients who had both a navigator and a peer connected to primary care at even higher rates.

Discussion: The use of mental health peers is becoming more common, particularly as mental health services are reorganizing into a recovery-based, versus an institutionally based, system. Future work should rigorously investigate the cost and long-term effectiveness of both peer supports and care navigation.

FOCUS POINTS

• Sixty percent of premature deaths in people with schizophrenia are due to causes such as cardiovascular and pulmonary conditions as well as infectious diseases.
• Increased mortality rates are due in part to patients’ difficulties in accessing medical care and to the lack of communication between psychiatry and primary care.
• Care navigators and mental health peer supports are examples of community-based supports for people with serious mental illness.
• In this study, both navigators and peers were effective in connecting patients from psychiatry to primary care; patients who had both a navigator and a peer connected to primary care at higher rates.
• Future work should rigorously investigate the cost and long-term effectiveness of both peer supports and care navigation.

INTRODUCTION

People with serious mental illness suffer excess mortality and die on average 25 years earlier, compared to the general population; 60% of premature deaths in people with schizophrenia are due to causes such as cardiovascular and pulmonary conditions as well as infectious diseases. This excess in morbidity resulting in early deaths is due in part to patients’ difficulties in accessing medical care and to the lack of communication between systems managing mental, behavioral, and physical health.

There is an increasing need for community resources that can support people with serious mental illnesses and assist with their connections to medical and mental health care. One
form of patient support is the patient “navigator,” most commonly used in cancer prevention and treatment programs.\textsuperscript{7,10} Navigators help patients to access appropriate and quality care.\textsuperscript{11} Activities common to navigator assistance include facilitating communication; improving care access; and providing outreach, education, and culturally competent care.\textsuperscript{12} Navigator interventions have also been effective in overcoming access barriers for people in underserved communities.\textsuperscript{8}

Mental health “peers,” in contrast, are consumer supports who are in recovery themselves. They can make a positive difference in the lives of people living with serious mental illness by lessening feelings of isolation and improving coping skills. Randomized and partially randomized trials have demonstrated that the use of mental health peers in the community supported recovery and lowered crisis services treatment use and costs, positively influenced attendance at support meetings, and resulted in better social functioning and more favorable psychosocial outcomes for mental health consumers.\textsuperscript{13-15}

In prior work, the authors of this article have reported on the effectiveness of a care navigator intervention to help patients link to primary care after a psychiatric crisis. The authors first looked at connection rates to primary care at 3 months post intervention, finding a statistically significant difference between the intervention and control groups.\textsuperscript{16} A subsequent analysis at 12 months replicated the earlier finding.\textsuperscript{17} In addition to the care navigator, the patients in the study had access to mental health peer supports; however, the effectiveness, if any, of the peer is not known. Therefore, the objective of the current report was to evaluate the effectiveness of a peer, independent of a care navigator, on connection to primary care. The primary research question was to determine if a mental health peer was effective in helping patients access primary care. If evidence was found to support the effectiveness of a peer, the authors then examined if there was a synergistic effect of having both a navigator and a peer.

METHODS

Between 2002–2006, study participants (N=175) were recruited from a psychiatric emergency room as part of a randomized trial examining access to primary care after a psychiatric crisis. Patients randomly assigned to the intervention group had the services of primary care navigators, versus patients in the control group who did not receive the navigator services. Mental health peers were available and their services were offered to patients in each group (intervention and control).

Eligibility criteria required that participants be ≥18 years of age, diagnosed with a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition—Text Revision\textsuperscript{18} defined Axis I disorder, and have no regular primary care provider. Patients were ineligible if actively suicidal or homicidal or if otherwise unable to give informed consent. In the case of patients admitted to the hospital for stabilization, they were eligible for enrollment once stabilized and ready for discharge. The prospective 1-year follow-up occurred from the point of hospital discharge. This study was approved through the State University of New York at Buffalo's Institutional Review Board.

Usual Care

Care for both intervention and control groups included services routinely offered through the psychiatric emergency ward: complete psychiatric assessment and management, targeted therapeutic approaches, linkages to community mental health services, and needed psychiatric medications. Uninsured patients were given on-site assistance with health insurance applications. Mental health peers were a service provided through the psychiatric emergency ward, available to all patients upon study enrollment.

Patients in the control group were contacted monthly by study personnel and asked about attendance at primary and mental healthcare sites, use of peers, and emergency room visits.

Intervention Group

In addition to the services noted above, participants randomized to the study’s intervention group were again offered a peer support from a peer who was part of the study team. Intervention group patients were assigned care navigators who met routinely with patients and maintained regular contact through face-to-face visits and bi-monthly telephone contact. Navigators provided additional services that included facilitation of access to primary medical care, home visits, mobile outreach when appropriate, and attendance at a primary care office visit if requested by the patient. Navigators also provided information on health, wellness, and medications.

The focus of this report is to examine if a peer, regardless of the use of a care navigator, impacted connection to primary care. Peers provided a variety of services. All peers were employed by a local community organization, the Independent Living Center, Inc., a peer-driven advocacy organization dedicated to “facilitating self-directed growth, wellness and choice through continuous peer mentoring.”\textsuperscript{19} Peers are salaried employees and are reimbursed for their services. They receive formalized training; the curriculum includes all aspects of peer advocacy, empowerment, self-help facilitator training, ways to address stigma, and understanding the lived experience of mental illness. Community speakers are incorporated into the training modules.

Peers focused on the client’s wellness and recovery as well as on reducing social isolation through community supports. They provided connections to social services and community health and drug and alcohol rehabilitation care sites by arranging appointments and providing transport. Peer support was
available for housing, education, and career goals as well as to assist with justice concerns. They reinforced patient education and teaching that may have occurred at primary care visits, and they assisted with the coordination of pharmacy and referral needs. Educational brochures about health and health care were distributed, and clients were encouraged to attend local “block club” meetings.

The primary outcome of interest was the connection rates to primary care on the basis of peer supports. Connection to primary care was evaluated over the course of the year of enrollment in the study. Connection was defined as completing at least one routine visit to a primary care provider.

RESULTS

At baseline, 175 participants were enrolled in the study. Thirty-eight percent of the sample was male, and 64% of participants were unemployed. Almost half of the sample (47%) ranged from 30–49 years of age; 28% of patients were 18–30 years of age. Self-identified African Americans comprised 38% of the sample, and 48% identified as Hispanic. The majority of this sample had either high school or some college education (92%). The most prevalent psychiatric diagnoses were psychotic, mood, and substance use disorders (37% of the sample had a co-existent substance use disorder). Approximately 50% of the sample had at least one medical comorbidity, such as diabetes, hypertension, or asthma.

Basic descriptive statistics were used to characterize the participants. Independent sample t-tests were used to examine the relation between connection rates to care on the basis of having a peer versus no peer. Chi-square analyses were used to examine potential differences between individuals with a peer compared to those without a peer. Upon significant findings of an impact of a peer on connection rates, an analysis of variance (ANOVA) was used to compare connection rates on the basis of both peer and navigator (four groups: no peer, no navigator; peer, no navigator; no peer, navigator; peer and navigator). Upon a significant omnibus F test within the ANOVA, pairwise comparisons were examined using a Scheffe correction for the multiple comparisons.

Of the 175 patients, 20.6% (n=36) had a peer and 79.4% (n=139) did not have a peer. The two groups were comparable at baseline with respect to diagnosis, age, gender, ethnicity, education, and income level. In terms of connection to primary care, there was a significant improvement in connection to primary care on the basis of a peer. Among those with a peer, 86% were able to connect to primary care compared to only 53% of individuals without a peer (P<.01). From Griswold and colleagues’ prior work, the use of a care navigator was associated with greater rates of connection to primary care. However, it was not clear if there was a synergistic impact of having both a navigator and peer helping patients connect to primary care.

Therefore, to examine the possible synergistic impact of having both a navigator and a peer, the authors examined four groups of individuals. In terms of the four groups, 46.8% of the sample did not have a peer or navigator; 32.5% did not have a peer but had a navigator; 16.0% had a peer but not a navigator; and 4.7% had both a peer and a navigator. In terms of connection to care, those with neither a peer nor navigator had the lowest connection rates to primary care (40%). Individuals with a navigator only connected at a rate of 71% while those with a peer only had a connection rate of 62.5%. Individuals with both a peer and navigator had the highest connection rate (92.8%). The results of the ANOVA were significant, indicating significant group differences (F(3, 174)=11.48, P<.001). The results of the pairwise comparisons indicated significant differences between the participants with neither a peer nor a navigator compared to the navigator only group (P<.01). There was also a significant difference between the group with neither peer nor navigator support, and the group with both a peer and navigator (P<.001).

DISCUSSION

In this group of adults with Axis I disorders presenting in psychiatric crisis, patients with peer supports were statistically more likely to make connections to primary medical care. Moreover, there was evidence to suggest that those patients who had both a navigator and a peer had the highest rates of connection to primary care. These findings provide some evidence of the positive benefit of a peer connection, and in this study did support a model of peers working with patients following a psychiatric crisis.

The use of mental health peers is becoming more common, particularly as mental health services are reorganizing into a recovery-based, versus an institutionally based, system. In a recent report, a “recovery-based” system is seen to rely on “self-determination, empowering relationships based on trust, understanding, and respect, meaningful roles in society, and elimination of stigma and discrimination.” In one study, mental health peers were incorporated into a community health system to lessen the physical health burdens experienced by people with serious mental illness. The focus of peer outreach in that study was to enhance access to medical care and to be a part of rigorous evaluation of health outcomes in the selected population. Early results indicated positive changes in lifestyles, including reductions in tobacco use.

Studies have examined peer effects in populations with mental disorders, looking at hospitalization rates, quality of life, and social functioning, with varying results.

This study looked specifically at connections to medical care, an important component of person-centered care and one that is pivotal to a population living with mental illness as evidence is increasingly clear that people with serious mental illnesses
suffer an elevated mortality rate compared to the general population—mostly due to medical conditions.1

This study has several important limitations. Though evidence was found to support the possibility of a synergistic impact of having both a peer and a navigator, this was a small sample of adults. The study did not control for prior interactions that patients may have had with peers, which could have enhanced or deterred the magnitude of the effects noted. Furthermore, mental health peers were not assigned randomly to patients, and there may have been a selection bias. Finally, it was difficult to ascribe tasks between the care navigator and the peer that were mutually exclusive. Ongoing work can more carefully describe differences and similarities between tasks provided by each intervention to more clearly assess the effectiveness of peer support and care navigation, and also to evaluate patient health outcomes.

A combination of care navigation and mental health peer support might be a powerful way to enhance care access. Future work should more rigorously investigate the cost and long-term effectiveness of care navigation and peer supports on both healthcare outcomes and their value added components of care.

CONCLUSION

An objective of a possible new systems configuration23 would be to utilize mental health peers as an integral part of the community supports offered to people with serious mental illness. Such supports may be one essential ingredient of a coordinated and patient-centered mental health and primary care system. PP

REFERENCES