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The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness

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ABSTRACT

Objectives: Persons with serious mental illnesses (SMI) have elevated rates of comorbid medical conditions, but may also face challenges in effectively managing those conditions.
Methods: The study team developed and pilot-tested the Health and Recovery Program (HARP), an adaptation of the Chronic Disease Self-Management Program (CDSMP) for mental health consumers. A manualized, six-session intervention, delivered by mental health peer leaders, helps participants become more effective managers of their chronic illnesses. A pilot trial randomized 80 consumers with one or more chronic medical illness to either the HARP program or usual care.
Results: At six month follow-up, participants in the HARP program had a significantly greater improvement in patient activation than those in usual care (7.7% relative improvement vs. 5.7% decline, $p=0.03$ for group time interaction), and in rates of having one or more primary care visit (68.4% vs. 51.9% with one or more visit, $p=0.046$ for group time interaction). Intervention advantages were observed for physical health related quality of life (HRQOL), physical activity, medication adherence, and, and though not statistically significant, had similar effect sizes as those seen for the CDSMP in general medical populations. Improvements in HRQOL were largest among medically and socially vulnerable subpopulations.
Conclusions: This peer-led, medical self-management program was feasible and showed promise for improving a range of health outcomes among mental health consumers with chronic medical comorbidities. The HARP intervention may provide a vehicle for the mental health peer workforce to actively engage in efforts to reduce morbidity and mortality among mental health consumers.

1. Introduction

Persons with serious mental illness (SMI) are at elevated risk for a host of chronic medical conditions, (Jeste et al., 1996; Goldman, 2000; Dickey et al., 2002; Jones et al., 2004; Sokal et al., 2004; Carney et al., 2006; Carney and Jones, 2006; Leucht et al., 2007; Meyer and Nasrallah, 2009). At the same time, they also face a series of barriers to effectively manage

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those illnesses. Physical inactivity (Brown et al., 1999; Daumit et al., 2005), poor diet, (McCreadie et al., 1998) problems with adherence to somatic medications (Kreyenbuhl et al., 2008), and limited health literacy (Dickerson et al., 2005, 2009) may both increase the incidence of illness and raise challenges to managing those conditions after they have developed.

Within the general medical literature, there is a growing recognition of the value of interventions that improve patient self-management of chronic medical conditions (Monninkhof et al., 2003; Chodosh et al., 2005; Effing et al., 2007). These programs work to improve an individual's ability to manage his or her illness and health behaviors and act as an effective patient (Hibbard et al., 2004).

Peer specialists make up one of the most rapidly growing segments of the mental health workforce in the US. These peers are trained to work in a variety of different settings to promote mental health recovery and wellbeing (Davidson et al., 1999, 2006; Cook, 2005). Amidst growing concern in the mental health consumer community about elevated morbidity and premature mortality (Parks and Svedsen, 2006), mental health consumer leaders are increasingly calling for efforts to incorporate physical health and wellness into existing consumer recovery programs (Fricks, 2009). However there are currently no evidence-based interventions available to do so.

This study adapted an established medical disease self-management program to be delivered by, and to, mental health consumers. This manuscript describes the development of the program and results of a pilot study designed to assess its feasibility and potential to improve self-management and health outcomes.

2. Methods

2.1. Overview of the Chronic Disease Self Management Program (CDSMP)

The intervention builds on the Chronic Disease Self Management Program (CDSMP) developed by Lorig et al at the Stanford Patient Education Center (Lorig, 1999, 2006). CDSMP programs are led by two peer educators with chronic medical conditions; any given group typically includes participants with a range of chronic conditions such as diabetes and arthritis. A series of six group sessions addresses self-management tasks that have been found to be common across chronic health conditions (Clark et al., 1991; Hibbard et al., 2007; Mosen et al., 2007). The elements of the intervention include regular action planning and feedback, modeling of behaviors and problem-solving by participants, reinterpretation of symptoms, and training in specific disease management techniques. In multiple studies, the CDSMP has shown to improve disease self management, health services use, and clinical outcomes (Lorig et al., 1999, 2001, 2008, 2009).

2.2. Adapting the Chronic Disease Self Management Program for Mental Health Consumers

The study adapted the CDSMP to mental health consumers using the iterative “ADAPT-ITT” approach for adaptation of evidence-based interventions developed by Wingood and DiClemente (Wingood and DiClemente, 2008). An expert panel comprised of mental health consumer leaders, a health educator, and the developer of the CDSMP was convened to consider the specific issues faced by persons with serious mental illness in managing their medical needs, and how these factors should be taken into consideration in modifying the intervention.

Peer leaders led a pre-pilot trial of the unmodified CDSMP with 8 subjects, followed by a series of two focus groups led by the health educator with those participants. The expert panel reviewed the results and then made recommendations about revisions to the manual. The health educator made the appropriate changes, which were reviewed and approved by the expert panel.

While the core structure of the program was retained, several modifications were made to adapt it to the needs and characteristics of mental health consumers. Because of potential gaps in health literacy and cognitive limitations (Dickerson et al., 2005, 2009), the manual was simplified to a sixth-grade reading level and a self-management record was added to track disease-specific self-management, medications, upcoming appointments, dietary intake, and physical activity To improve motivation and engagement in care, each participant was paired with a partner from the group, with the two working together toward accomplishing action plans and goals.

Materials were added emphasizing the connection between mind and body, and a section was added about the importance of coordinating information about medications between primary care providers and psychiatrists. The section on medical advanced directives was expanded to also include mental health advanced directives, which specify preferences if a client is unable to make decisions due to psychiatric symptoms.

Finally, the diet and exercise sections were modified to address the high rates of poverty and social disadvantage in this population. The diet section provided strategies for purchasing healthy food on a budget (including using food stamps) and strategies were provided to allow participants to safely exercise in their own homes.

2.3. Randomized Trial

Subsequently, a small randomized trial was conducted at a Community Mental Health Center (CMHC) to establish feasibility, effectiveness, and to inform further studies of the program in this population. All study participants gave written, informed consent, and the study was approved by the University's Institutional Review Board.

2.3.1. Study setting

The study was conducted at an urban CMHC. The target population of the facilities is individuals age 18 and older from the area that experience serious and persistent mental illness with or without comorbid addictive disorders.

2.3.2. Sample recruitment

The sample was recruited through waiting rooms and flyers posted in outpatient clinics at the two facilities. This dual approach has been found to be optimal for recruiting vulnerable populations for health behavior interventions (Harris et al., 2003). To be eligible, subjects had to be on the