

# "I've been there too": Peers in co-occurring services and relationship to fidelity

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### Abstract

Individuals with co-occurring illnesses are at risk for poor outcomes related to criminal justice, hospitalization, housing, and employment. High fidelity evidence-based practice models, including Integrated Dual Disorder Treatment (IDDT), are associated with significant improvements in outcomes. Implementation of IDDT is measured using a 26 item fidelity scale. In Michigan, IDDT has been altered by adding peer specialists, people with lived experience with mental illness and substance use disorders, to treatment teams in some of 68 IDDT teams and 122 fidelity reviews. IDDT fidelity improved significantly over time ( $F(6, 115)=6.60$ ,  $p<.001$ ), even with the systematic addition of peers to the IDDT workforce. Almost 85% of teams had a peer, and 33% of reviews included a full-time peer. Having a full-time peer on the IDDT team was significantly associated with higher total fidelity scores ( $F(2, 30)=6.40$ ,  $p<.01$ ). The addition of peers as part of interdisciplinary care has promise to impact high quality services for people with co-occurring illnesses. Implications for team composition and future research are discussed.

### Introduction

- > 50% with a Serious Mental Illness (SMI) also have a Substance Use Disorder (SUD)<sup>1</sup>
- > Outcomes for CODs are worse in: Incarceration, Hospitalization, Homelessness, Unemployment, and Health<sup>2,3</sup>
- > Peers = people with lived recovery experience of serious mental illness
- > Peers are correlated with less hospitalization, lower self-reported rates of drug-use, and improved housing outcomes<sup>6,7</sup>
- > IDDT<sup>4,5</sup> practiced with practice alteration of peers since 2007 throughout one state
- > Research Questions: 1) How does IDDT fidelity differ when a large scale evidence-based practice alteration, the addition of peers, is added? 2) What is the relationship between peer status (no peer, part-time peer, or full-time peer) on IDDT teams and IDDT fidelity in a multi-team?

### Methods

#### Study Sample:

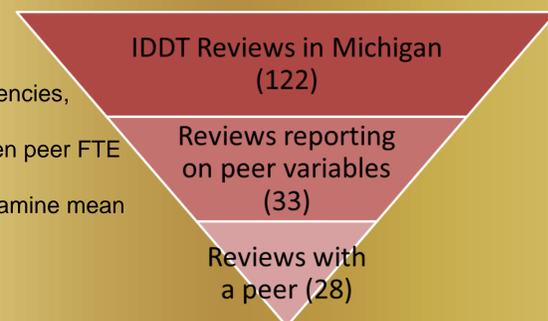
- > Fidelity review data of all IDDT teams in Michigan from 2006-2012 (122 yearly reviews, 68 teams)
- > Peer team member data self-report from IDDT team leaders (33 reviews, 20 teams)

#### Variables:

Variable Type	Variable Name	Measurement	Values
Predictor	Peer	Dichotomous	0/1
Predictor	Peer FTE	Ordinal	0/1/2
Outcome	Total Fidelity	Continuous	1.00 – 5.00
Outcome	High Fidelity	Dichotomous	0/1

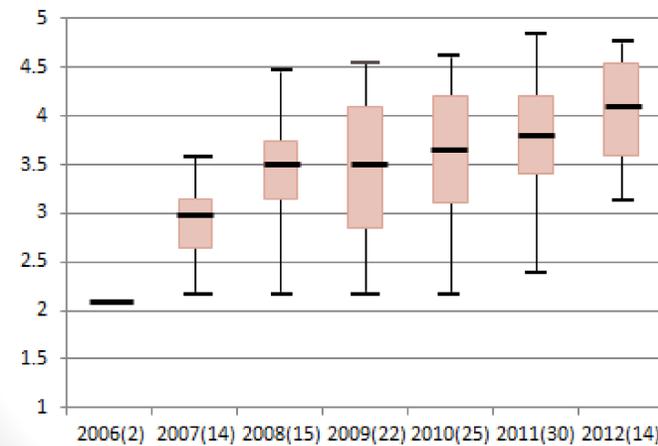
#### Statistical Analysis:

- > SPSS v. 20, alpha = .05
- > Evaluation of univariate frequencies, and bivariate
- > T-tests for relationship between peer FTE and fidelity
- > Analysis of the variance to examine mean fidelity by peer status and time

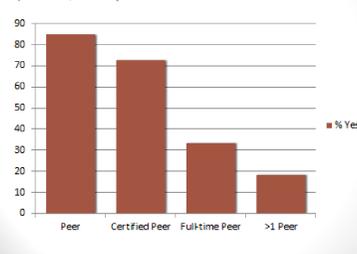


### Results

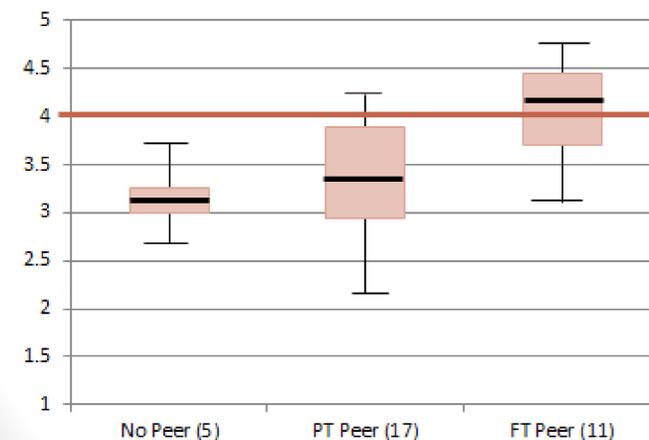
IDDT fidelity over time one way ANOVA (N=122) (MiFAST, 2013) ( $F(6, 115)=6.60$ ;  $p<.001$ )



Frequency of Peers on IDDT teams (N=33) (MiFAST, 2013)



One-Way ANOVA of peer and model fidelity (N=33) (MiFAST, 2013) ( $F(2, 30)=6.40$ ,  $p<.01$ )



### Summary

- > Teams reporting on peers had a peer 84.8% of reviews, and a full-time peer 33% of reviews
- > IDDT improves over time, even with the alteration of peers
- > Having a full-time peer is associated with higher fidelity, with a mean in the clinically important high fidelity range

### Conclusion

#### Study limitations:

- > Response rate 27% for peer team data
- > Total team staffing could be higher for teams with peers
- > Confounding variables or reverse causation possible - high fidelity teams hire peers

#### Future Research:

- > Effect of peers on clinical outcomes directly
- > Factorial analysis of peers on individual fidelity items, and individual fidelity items on clinical outcomes
- > Qualitative analysis of the experience of being a peer specialist

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### Acknowledgements

- > To the Western Michigan University Interdisciplinary Health Sciences Doctoral Program
- > MiFAST reviewers throughout Michigan
- > Peers who share their recovery to help others in the same process