Peer support: Addition of a peer specialist to the treatment team

Adult Mental Health: Serious Mental Illness

Benefit-cost estimates updated December 2023. Literature review updated May 2014.

Current estimates replace old estimates. Numbers will change over time as a result of model inputs and monetization methods.

The WSIPP benefit-cost analysis examines, on an apples-to-apples basis, the monetary value of programs or policies to determine whether the benefits from the program exceed its costs. WSIPP's research approach to identifying evidence-based programs and policies has three main steps. First, we determine "what works" (and what does not work) to improve outcomes using a statistical technique called meta-analysis. Second, we calculate whether the benefits of a program exceed its costs. Third, we estimate the risk of investing in a program by testing the sensitivity of our results. For more detail on our methods, see our Technical Documentation.

Program Description: The programs examined in this analysis compared treatment teams with a peer specialist to treatment teams without a peer specialist. The treatment teams in this analysis provided services to individuals with serious mental illness or individuals receiving VA services for a psychiatric diagnosis.

Benefit-Cost Summary Statistics Per Participant

Benefits to:

Taxpayers	$3,086
Participants	$6,900
Others	$36
Indirect	($1,992)
Total benefits	$8,030
Net program cost	($4,142)
Benefits minus cost	$3,888

Benefit to cost ratio	$1.94
Benefits minus costs	$3,888
Chance the program will produce benefits greater than the costs	84%

The estimates shown are present value, life cycle benefits and costs. All dollars are expressed in the base year chosen for this analysis (2022). The chance the benefits exceed the costs are derived from a Monte Carlo risk analysis. The details on this, as well as the economic discount rates and other relevant parameters are described in our Technical Documentation.

Meta-Analysis of Program Effects

Outcomes measured	Treatment age	No. of effect sizes	Treatment N	Adjusted effect sizes and standard errors used in the benefit-cost analysis						Unadjusted effect size (random effects model)	
				First time ES is estimated			Second time ES is estimated				
				ES	SE	Age	ES	SE	Age	ES	p-value
Crime^^	46	1	36	0.000	0.243	46	n/a	n/a	n/a	0.000	1.000
Employment	46	1	78	0.386	0.133	46	0.000	0.000	47	0.386	0.004
Global functioning^	46	1	78	0.685	0.135	46	n/a	n/a	n/a	0.685	0.001
Hospitalization (psychiatric)	46	7	2191	-0.064	0.123	46	0.000	0.000	47	-0.064	0.604
Homelessness^	46	1	36	-0.138	0.243	46	n/a	n/a	n/a	-0.138	0.569
Psychiatric symptoms^	46	3	274	0.044	0.080	46	n/a	n/a	n/a	0.044	0.552

^WSIPP's benefit-cost model does not monetize this outcome.

^^WSIPP does not include this outcome when conducting benefit-cost analysis for this program.

Meta-analysis is a statistical method to combine the results from separate studies on a program, policy, or topic in order to estimate its effect on an outcome. WSIPP systematically evaluates all credible evaluations we can locate on each topic. The outcomes measured are the types of program impacts that were measured in the research literature (for example, crime or educational attainment). Treatment N represents the total number of individuals or units in the treatment group across the included studies.

An effect size (ES) is a standard metric that summarizes the degree to which a program or policy affects a measured outcome. If the effect size is positive, the outcome increases. If the effect size is negative, the outcome decreases.

Adjusted effect sizes are used to calculate the benefits from our benefit cost model. WSIPP may adjust effect sizes based on methodological characteristics of the study. For example, we may adjust effect sizes when a study has a weak research design or when the program developer is involved in the research. The magnitude of these adjustments varies depending on the topic area.

WSIPP may also adjust the second ES measurement. Research shows the magnitude of some effect sizes decrease over time. For those effect sizes, we estimate outcome-based adjustments which we apply between the first time ES is estimated and the second time ES is estimated. We also report the unadjusted effect size to show the effect sizes before any adjustments have been made. More details about these adjustments can be found in our Technical Documentation.

Detailed Monetary Benefit Estimates Per Participant

Affected outcome:	Resulting benefits:[1]	Benefits accrue to:				
		Taxpayers	Participants	Others[2]	Indirect[3]	Total
Employment	Labor market earnings	$2,928	$6,898	$0	$0	$9,826
Hospitalization (psychiatric)	Health care associated with psychiatric hospitalization	$158	$2	$36	$79	$275
Program cost	Adjustment for deadweight cost of program	$0	$0	$0	($2,071)	($2,071)
Totals		$3,086	$6,900	$36	($1,992)	$8,030

[1]In addition to the outcomes measured in the meta-analysis table, WSIPP measures benefits and costs estimated from other outcomes associated with those reported in the evaluation literature. For example, empirical research demonstrates that high school graduation leads to reduced crime. These associated measures provide a more complete picture of the detailed costs and benefits of the program.

[2]"Others" includes benefits to people other than taxpayers and participants. Depending on the program, it could include reductions in crime victimization, the economic benefits from a more educated workforce, and the benefits from employer-paid health insurance.

[3]"Indirect benefits" includes estimates of the net changes in the value of a statistical life and net changes in the deadweight costs of taxation.

Detailed Annual Cost Estimates Per Participant

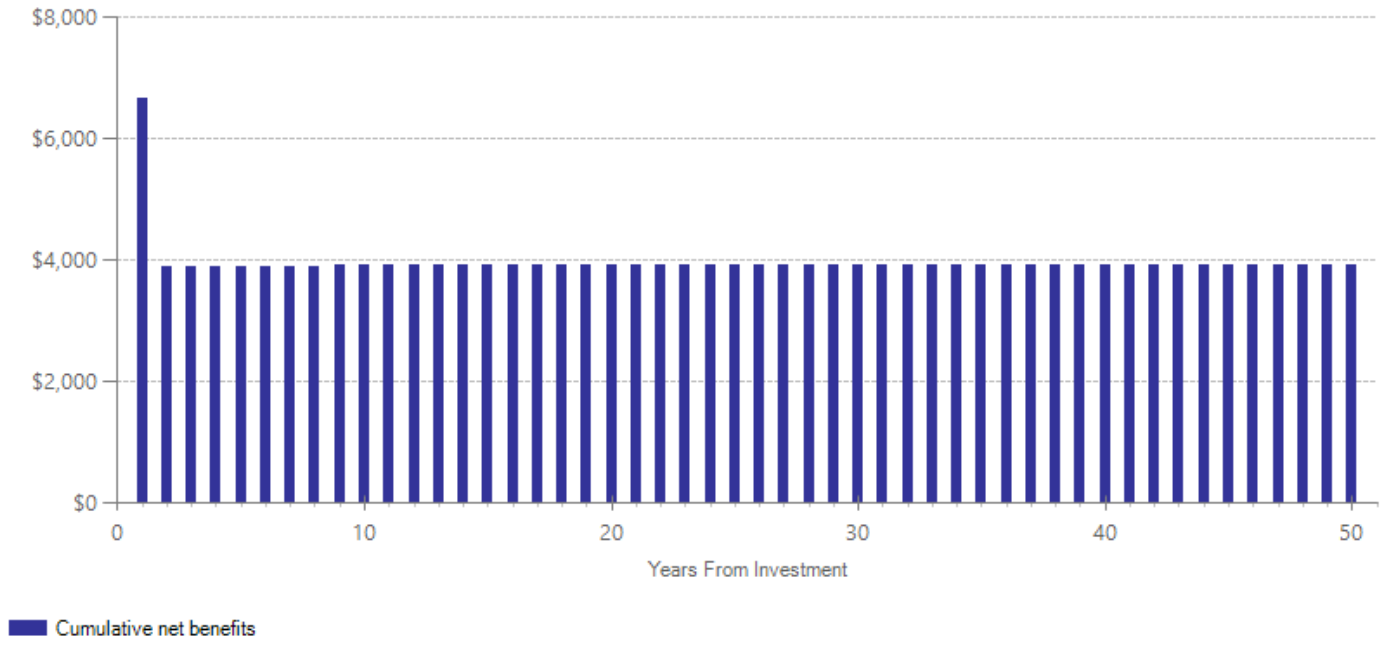
	Annual cost	Year dollars	Summary	
Program costs	$1,842	2011	Present value of net program costs (in 2022 dollars)	($4,142)
Comparison costs	$0	2011	Cost range (+ or -)	10%

The cost of treatment is the weighted average cost of peer services provided in the studies included in this analysis. The average number of service hours is estimated from Eisen et al., 2012, Felton et al., 1995, and Sledge et al., 2011 is higher than the average number of encounters with a peer specialist in Washington State as reported in Mercer (2013). The cost per encounter was estimated using the peer specialist reimbursement cost reported in Mercer, (2013).

Felton et al., (1995). Consumers as peer specialists on intensive case management teams: Impact on client outcomes. *Psychiatric Services, 46*(10), 1037-1044.
Sledge et al., (2011). Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. *Psychiatric Services, 62*(5), 541-544.
Eisen et al., (2012). Outcome of a randomized study of a mental health peer education and support group in the VA. *Psychiatric Services, 63*(12), 1243-1246.
Mercer, (2013). Behavioral health data book for the state of Washington for rates effective January 1, 2014.

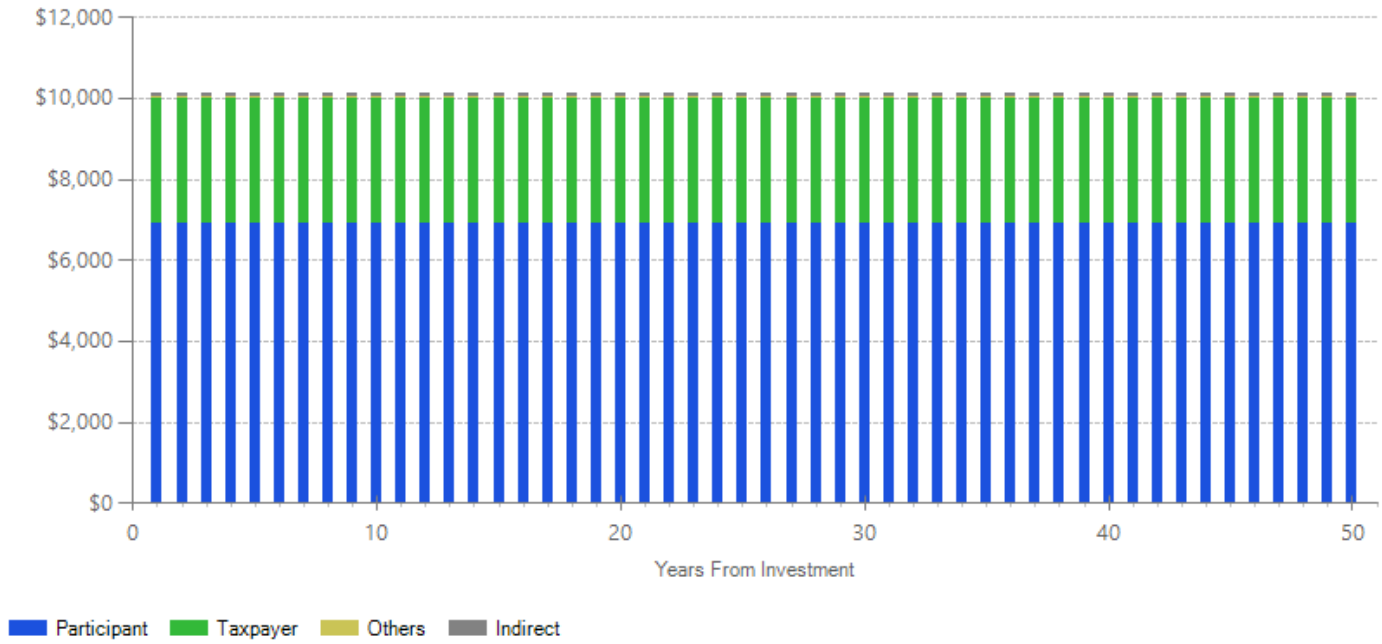
The figures shown are estimates of the costs to implement programs in Washington. The comparison group costs reflect either no treatment or treatment as usual, depending on how effect sizes were calculated in the meta-analysis. The cost range reported above reflects potential variation or uncertainty in the cost estimate; more detail can be found in our Technical Documentation.

Benefits Minus Costs Over Time (Cumulative Discounted Dollars)



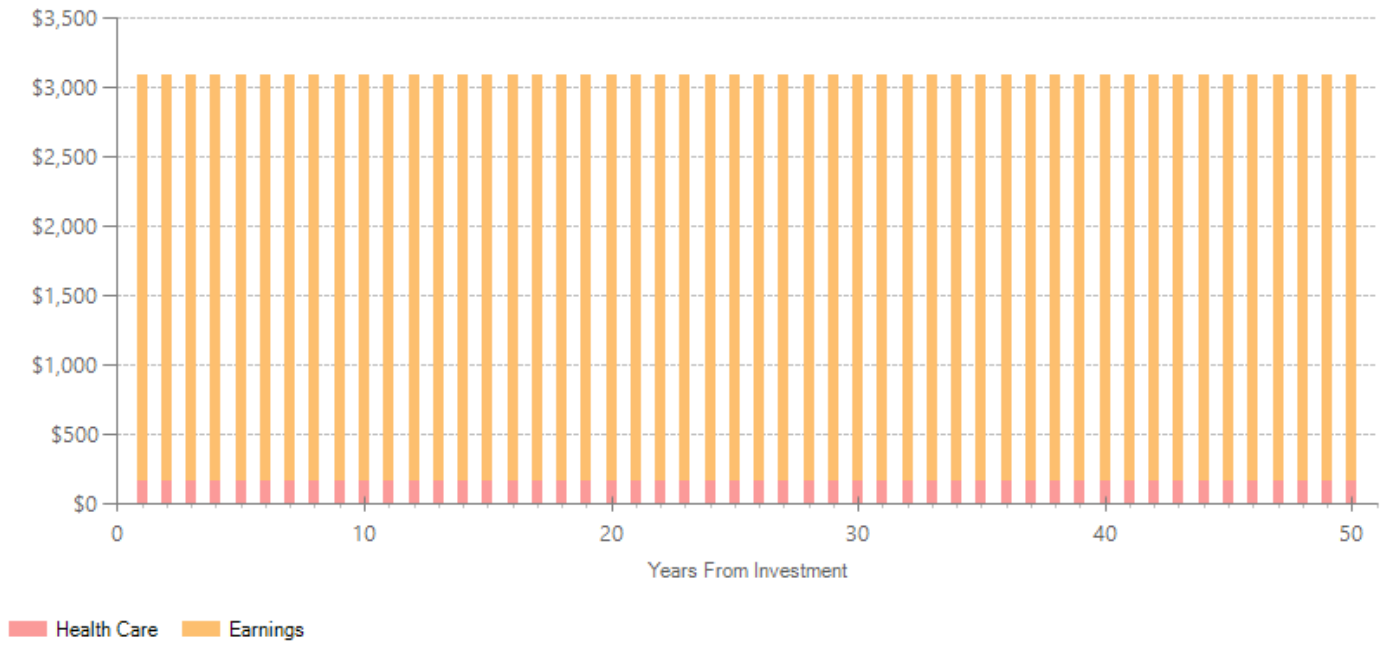
The graph above illustrates the estimated cumulative net benefits per-participant for the first fifty years beyond the initial investment in the program. We present these cash flows in discounted dollars. If the dollars are negative (bars below $0 line), the cumulative benefits do not outweigh the cost of the program up to that point in time. The program breaks even when the dollars reach $0. At this point, the total benefits to participants, taxpayers, and others, are equal to the cost of the program. If the dollars are above $0, the benefits of the program exceed the initial investment.

Benefits by Perspective Over Time (Cumulative Discounted Dollars)



The graph above illustrates the breakdown of the estimated cumulative benefits (not including program costs) per-participant for the first fifty years beyond the initial investment in the program. These cash flows provide a breakdown of the classification of dollars over time into four perspectives: taxpayer, participant, others, and indirect. “Taxpayers” includes expected savings to government and expected increases in tax revenue. “Participants” includes expected increases in earnings and expenditures for items such as health care and college tuition. “Others” includes benefits to people other than taxpayers and participants. Depending on the program, it could include reductions in crime victimization, the economic benefits from a more educated workforce, and the benefits from employer-paid health insurance. “Indirect benefits” includes estimates of the changes in the value of a statistical life and changes in the deadweight costs of taxation. If a section of the bar is below the $0 line, the program is creating a negative benefit, meaning a loss of value from that perspective.

Taxpayer Benefits by Source of Value Over Time (Cumulative Discounted Dollars)



The graph above focuses on the subset of estimated cumulative benefits that accrue to taxpayers. The cash flows are divided into the source of the value.

Citations Used in the Meta-Analysis

Chinman, M., Oberman, R.S., Hanusa, B.H., Cohen, A.N., Salyers, M.P., ... & Young, A.S. (2014). A cluster randomized trial of adding peer specialists to intensive case management teams in the veterans' health administration. *The journal of behavioral health services & research,* 1-13.

Craig, T., Doherty, I., Jamieson-Craig, R., Boocock, A., & Attafua, G. (2004). The consumer-employee as a member of a Mental Health Assertive Outreach Team I Clinical and social outcomes. *Journal of Mental Health, 13*(1), 59-69.

Eisen, S.V., Schultz, M.R., Mueller, L.N., Degenhart, C., Clark, J.A., Resnick, S.G., Christiansen, C.L., ..., & Sadow, D. (2012). Outcome of a randomized study of a mental health peer education and support group in the VA. *Psychiatric Services, 63*(12), 1243-1246.

Felton, C.J., Stastny, P., Shern, D.L., Blanch, A., Donahue, S.A., Knight, E., & Brown, C. (1995). Consumers as peer specialists on intensive case management teams: Impact on client outcomes. *Psychiatric Services, 46*(10), 1037-1044.

Gordon, R.E., Edmunson, E., Bedell, J. & Goldstein, N. (1979). Reducing rehospitalization of state mental patients. *Journal of the Florida Medical Association, 66*(9), 927-933.

Landers, G.M., & Zhou, M. (2011). An analysis of relationships among peer support, psychiatric hospitalization, and crisis stabilization. *Community Mental Health Journal, 47*(1), 106-112.

Min, S.Y., Whitecraft, J., Rothbard, A.B., & Salzer, M.S. (2007). Peer support for persons with co-occurring disorders and community tenure: a survival analysis. *Psychiatric Rehabilitation Journal, 30*(3), 207-213.

Resnick, S.G., & Rosenheck, R.A. (2008). Integrating peer-provided services: a quasi-experimental study of recovery orientation, confidence, and empowerment. *Psychiatric Services : a Journal of the American Psychiatric Association, 59*(11), 1307-1314.

Sledge, W.H., Lawless, M., Sells, D., Wieland, M., O'Connell, M.J., & Davidson, L. (2011). Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. *Psychiatric Services, 62*(5), 541-544.

Tracy, K., Burton, M., Nich, C., & Rounsaville, B. (2011). Utilizing peer mentorship to engage high recidivism substance-abusing patients in treatment. *The American Journal of Drug and Alcohol Abuse, 37*(6), 525-531.

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