PeerLink Evaluation Report

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by

Yale Program for Recovery and Community Health

Chyrell D Bellamy, PhD, MSW

Ashley Clayton, MA

Larry Davidson, PhD

Maria O'Connell, PhD

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For more information please contact: Dr. Chyrell Bellamy (chyrell.bellamy@yale.edu) or Dr. Maria O'Connell (maria.oconnell@yale.edu) at the Yale Program for Recovery and Community Health, www.yale.edu/prch

Executive Summary

Background:
The last decade has experienced a substantial increase in the development of peer-provided services for adults with serious mental illness, yet empirical evidence supporting these interventions unfortunately lags behind their rapid proliferation. The following report contains findings from a multi-pronged naturalistic evaluation of the PeerLink Pilot project, which focused particularly on individuals with a history of recurrent hospitalizations in Wisconsin and Tennessee from December 2009 through August 2010. The aims of the evaluation were to measure the outcomes of the pilot program and its impact on the lives of people with mental illness, as well as to gain a further understanding of the experiences of both peers and clinical staff involved in this process.

Description of Evaluation Process:
This pilot study employed a multilevel evaluation process as well as a collaborative approach to deciding which instruments were to be used to collect data, and for the development of focus groups and survey questions. Data were collected across all groups involved in the PeerLink Pilot, and ongoing meetings held to develop the evaluation with all partners exemplified the collaborative nature of the study. This report summarizes the collection and evaluation of five sources of data: 1) data from Peer Tracker, a tracking system to capture information about each PeerLink peer and participant contact (Study 1); 2) quantitative, point-in-time survey data collected on PeerLink participants (Study 2); 3) focus groups with PeerLink participants (Study 3); 4) online OptumHealth staff survey (Study 4); and 5) focus groups with PeerLink peer specialists (Study 5).

Results:
On average, participants had worked with their peer specialists for over 4 months, and had an average of 16 contacts with them. The major reasons for working with their peer specialist were to learn about recovery and mental health, to work on member's recovery plan, and to get support from someone with similar experiences. At the time of the survey, participants reported positive outcomes on measures of quality of life, recovery markers, state hope, social support, and mental health confidence. Those who reported participating in peer support for more instrumental reasons had higher scores on the Recovery Markers Scale.

Themes:
Focus group data revealed several key themes amongst participants. Individuals generally reported that they gained self-confidence and that the program instilled in them a focus on goals and a clearer sense of vision. They also expressed feeling more hopeful as a result of the program. In addition to these more abstract benefits, participants pointed towards practical assistance gained from peers, assistance that was distinctive because it came from someone with experience with mental illness; participants reported that they felt a sense of trust, support, and genuine understanding from those who had similar journeys. Finally individuals reported that peer support proved instrumental in helping them stay out of hospitals.

Contents

Background

Over the last decade, there has been a substantial increase in the development of peer-provided services for adults with serious mental illnesses. The proliferation of mutual support groups, the creation of consumer-run programs, and, most prominently, *the hiring of people with histories of mental illness as mental health providers* have all been viewed as integral components of the transformation and reorientation of mental health towards recovery called for by the U.S. Surgeon General in 1999 and by the 2003 President's New Freedom Commission on Mental Health. The empirical evidence supporting peer-provided services unfortunately lags behind their rapid proliferation. Very few studies evaluated ***peer support*** per se, (i.e., as opposed to peer case management), and even fewer evaluated those aspects of peer support which are thought to be unique to this form of service delivery. As a result, system leaders are left to balance an emphasis on evidence-based practices with the increasing pressures from the federal and state governments as well as advocacy groups to offer more peer-provided alternatives to conventional care.

The Pilot PeerLink's focus on peer support with individuals with a history of recurrent hospitalizations is of interest from both a scientific perspective and everyday practice perspective. Moreover, it has potential implications for public policy issues, such as cost effectiveness. The phenomenon of hospital recidivism, for example, remains a persistent clinical, personal, and social problem that has proven refractory to intervention. Perhaps the most promising clinical approach to this problem has been psycho-educational in nature, providing patients and their families with information about the nature of serious mental illness, the ongoing vulnerability to stress and need for medication, and the use of problem-solving strategies to decrease stress and the level of 'expressed emotion' in the family or residential environment. When targeting recidivism in particular, practitioners operate under the assumption that people are readmitted due to relapses. Thus, the standard approach has included an emphasis on identifying early warning signs of relapse—each person's unique 'relapse signature,' and monitoring patients closely to intervene early in the process of decompensation to avert full-blown episodes of disorder. Other research at Yale's Program for Recovery and Community Health (Yale-PRCH), however, has shown that readmissions may be due as much to social, environmental, and systemic factors as to clinical ones, perhaps accounting for the limited effectiveness of this 'prodromal recognition' approach. Foremost among the factors predicting readmission is the absence of social support, suggesting that this is a population that may be especially in need of, and receptive to, added peer support.

The following report contains findings from a multi-pronged naturalistic evaluation of the PeerLink Pilot project that took place in Wisconsin and Tennessee from December 2009 through August 2010. The PeerLink Pilot Project was a collaborative endeavor between the Yale Program for Recovery and Community Health, OptumHealth, and two peer-run organizations. The aims of this evaluation are to measure the outcomes of the PeerLink Pilot program and its

impact on the lives of people with mental illness as well as to gain a further understanding of the experiences of both peers and clinical staff involved in this process.

Description of PeerLink Project

Tennessee

Overview of the Pilot Program

The West Tennessee PeerLink pilot site took place in the TennCare environment. TennCare is a mandated Medicaid and CHIP managed care program for children and adults. The state contracts with two managed care companies in each section of the state – East, Middle, and West. Individuals can choose their managed care company.

TennCare covers medical and behavioral health services for members, including behavioral health services paid for through the Medicaid rehab option. Supported Housing, assertive community treatment, peer support and other psychosocial interventions are all managed by TennCare managed care companies. Each managed care company develops a network of providers to ensure that a full array of services is provided to members.

The state of Tennessee provides behavioral safety net services, outside of TennCare, for individuals diagnosed with serious and persistent mental illness who do not qualify for Medicaid.

PeerLink services were provided by Tennessee Mental Health Consumers' Association (TMHCA). TMHCA is a 100% consumer run statewide advocacy organization and a licensed psychosocial rehabilitation provider. They were contracted with two of the TennCare managed care companies and were providing peer support and psychosocial rehabilitation before the PeerLink pilot began.

TMHCA employed the full time Peer Specialists for the pilot and gathered the pilot data.

Many of the members in the PeerLink pilot In Tennessee lived in segregated housing and had participated in psychosocial groups prior to the pilot. Transportation is a covered service in the area of the PeerLink pilot.

Wisconsin

Overview of Pilot Program

The Wisconsin PeerLink pilot took place in three southeast Wisconsin counties as part of the BadgerCare Medicaid waiver. BadgerCare is mandated Medicaid managed care for individuals who receive TANF, CHIP, or SSI. Individuals can choose one of three managed care companies contracted by the state. If they don't choose, a managed care company will be assigned for them.

The BadgerCare managed care companies are required to provide medical and behavioral health services. The behavioral health services include inpatient care and traditional outpatient

services, such as therapy and partial hospitalization. The managed care companies can also provide value-added services such as in-home therapy.

More intense behavioral health services, such as psychosocial rehabilitation or other services reimbursed through the Medicaid rehab option are provided for eligible members who receive SSI, by county governments, through Community Support Programs (CSPs). Though many of the pilot members were in these programs, they are not part of BadgerCare and are not part of the managed care organizations' array of services.

In Wisconsin, Medicaid dollars are managed by each county and services may vary from county to county. In Milwaukee County, transportation is available for Medicaid reimbursed services but otherwise, transportation was not available for pilot members.

PeerLink services were provided by the following groups:

- The Gathering Place, a drop-in Clubhouse type program, served approximately 20 pilot members in Brown County.
- The Community Assessment Team (CAT), a consumer run part of NAMI Racine, served approximately 20 members in Racine County.
- NAMI Milwaukee managed and staffed by individuals with the lived experience of mental illness, provided services for approximately 45 pilot members in Milwaukee County.

All of the Peer Specialists were part time employees of these organizations. Grassroots Empowerment Project (GEP), a statewide consumer run advocacy organization, with various funding sources, contracted with one of the BadgerCare managed care organizations to coordinate the PeerLink pilot. GEP subcontracted with the three organizations to provide the peer support services. GEP ensured that the Peer Specialists were certified, provided training throughout the pilot, and gathered data for the pilot.

Description of Evaluation Process

This pilot study employed a multilevel, naturalistic evaluation of the implementation of PeerLink in two different states-- Wisconsin and Tennessee. Data were collected across all groups involved in the intervention—study participants, peer specialists, OptumHealth staff, and hospital/service use data in order to gain an understanding of the various aspects of the pilot intervention. Originally, six sources of data were analyzed: 1) data from Peer Tracker, a tracking system to capture information about each PeerLink peer and participant contact; 2) hospitalization data for a 20 month pre-post PeerLink period; 3) quantitative, point-in-time survey data collected on PeerLink participants; 4) focus groups with PeerLink participants; 5) online OptumHealth staff survey; and 6) focus groups with PeerLink peer specialists. It should be noted that the data across the six studies are not linked to one another, so inferences cannot be made about the interrelationship between the various constructs assessed in the

studies. Moreover, the findings presented in this report are preliminary, descriptive in nature and comparisons between sites or participants are limited.

Note: After the completion of this report, OptumHealth identified errors with the parameters of the hospitalization data provided by OptumHealth to Yale as well as how eligibility for analysis was defined. As a result, the preliminary analyses of hospitalization data that were conducted have not been included in this report. This current report therefore reports on 5 of the 6 data sources outlined above. Subsequent analysis of hospitalization data is available from OptumHealth for this study population. In addition, analyses are now under way on an expanded WI and TN population, allowing for a longer pre-post time period, taking benefit eligibility into account, and also linking the hospitalization data to Peer Tracker data. Results of these new analyses will be made available shortly from OptumHealth.

The selection of instruments and focus group questions, in addition to the overall evaluation design, were developed in a collaborative manner with all stakeholders in the process. Ongoing meetings were held to develop the evaluation with all partners exemplified the collaborative nature of the study. Groups discussed various options for survey instruments and decided as a team which measures might work best with the participants in this study. They also developed and revised questions for the peer focus groups and OptumHealth staff survey. In addition, peer partners also developed the study protocol, including the decision not to provide stipends for participation.

All peers took a HIPPA and human subjects training before administering the surveys to participants. All interviewers were instructed by the Yale research staff on the interviewing and consent process. Unless participants requested reading assistance, however, they typically completed their own surveys.

Peer specialists participated in focus groups via a teleconference process with participants from both sites on the calls. Questions were sent in advance so that everyone had time to look them over beforehand as a guide for the discussion. Rather than recording conversations, researchers took notes during the call. Survey questions for OptumHealth staff asked about their general understanding of the intervention and ways in which it could be improved.

Evaluation Study 1: Peer Tracker Data

Description. Data on the number and type of contacts that each peer had with participants were collected via a Peer Tracker database. The Peer Tracker database contained the following information about each point of contact or attempted contact between a PeerLink peer specialist and a program participant: year of birth, date of contact, type of contact (face to face, telephone, or attempt), length of visit (in minutes), and type of service provided (e.g., community living, community resources, general peer support).

Sample. Peer Tracker data were available on 43 participants from Tennessee and 83 participants from Wisconsin.

Results. On average, participants had worked with peer specialists for 4.17 months (*sd* = 2.50) and had an average of 16.13 (*sd* = 12.93) contacts with peers over the course of that period. Tennessee participants had significantly more face-to-face contacts with their peers (p <.001), while Wisconsin participants had significantly more telephone contacts with the peers (p < .001). The average length of each contact was significantly longer in Tennessee than Wisconsin (96 minutes versus 15 minutes), p <.001, likely due to the greater degree of face-to-face contacts. It should also be noted that there were different services offered at each site.

Table 1.

PeerLink Tracker Data

	Tennessee (n = 43)	**Wisconsin (n = 83)**	**p-value**
Average age of participant	45.52 (12.29)	36.98 (10.88)	.001
Average length of time working with peer (months)	3.60 (2.56)	4.46 (2.43)	.07
Average # of contacts with peers	17.67 (16.18)	15.35 (10.96)	.34
% Face to face contacts	90% (16%)	12% (12%)	.001
% telephone contacts	10% (16%)	67% (25%)	.001
Average # of contacts per month	3.48 (1.76)	2.94 (1.95)	.13
Average # ff contacts per month	3.17 (1.69)	.41 (.55)	.001
Average number of telephone contacts per month	.32 (.57)	1.96 (1.49)	.001
Average length of face-to-face contacts	110.9	68.79	.001
Focus of Contacts:			
- Community Living	.67 (1.13)	.91 (2.90)	.62
-Community Resources	Not assessed	1.6 (3.17)	
- General Peer Support	7.14 (10.21)	8.67 (7.82)	.35
IMR	3.16 (5.44)	Not assessed	
Initial Contact	Not assessed	1.04 (.81)	
Psych Rehab	5.70 (6.50)	Not assessed	
Social	.77 (1.85)	.68 (1.83)	.81
Support Group	2.93 (5.17)	Not assessed	
WRAP	Not assessed	1.34 (2.33)	

Evaluation Study 2: Quantitative Survey of PeerLink Participants

Design. The instruments for the survey were selected by a collaborative team which included Yale-PRCH, OptumHealth, and Peer involvement from Tennessee and Wisconsin. The survey was approved by Yale's Human Investigations Committee (HIC). The survey included the following instruments:

Reasons to Come Scale (RTC) (modified). The 19-item Reasons to Come Scale (Mowbray & Tan, 1993) was used to measure consumer-reported reasons for attending a program. All items were rated using a 3-point, Likert-type scale (0 = no, 1 = sometimes, 2 = yes). The instrument was modified to Reasons for Peer Support: Some People have described various *reasons for working with a peer specialist*. For each item below, circle the one answer that best describes whether each of these is a reason for you. Items included: "to learn about advocacy"; "to get help finding a job"; "because I have to"…. Mowbray, C. T., & Tan, C. (1993). Consumer-operated drop-in centers: Evaluation of operations and impact. *Journal of Mental Health Administration, 20* (1), 8-19.

Social Support was assessed through the *Social Support Questionnaire* [SSQ]. The SSQ measures 3 aspects of social support: instrumental, affirmative, and affective. This scale asks participants to list the members of their support system and then to rate them in terms of their supportiveness. Calculations as to both the size of an individual's support system and the person's satisfaction with the quality of support received can be obtained from this scale. The SSQ has been shown to have good reliability and validity [106]. Norbeck, J.S., Lindsay, A.M., & Carrieri, V.L. (1981). The development of an instrument to measure social support. *Nursing Research*, 30, 264-269; Norbeck, J.S., Lindsay, A.M., & Carrieri, V.L. (1983). Further development of the Norbeck Social Support Questionnaire: Normative data and validity testing. *Nursing Research*, 32, 4-9. Byers, J.A., Mullis, L.A. (1987). The Norbeck Social Support Questionnaire: Reliability and validity. *Education and Psychological Measurement*, 4, 445-458.

Mental Health Confidence Scale is a 16-item scale measuring dimensions specific to self-efficacy/confidence in the lives of people with mental illness. It has been found to have an alpha = .94. Carpinello, S.E.; Knight, E.L.; Markowitz, F.E.; & Pease, E.L. (2000). The development of the Mental Health Confidence Scale: A measure of self-efficacy in individuals diagnosed with mental disorders*. Psychiatric Rehabilitation Journal,* 23, 236-243.

Quality of Life (one question – global assessment); The Quality of Life measure [QOL] is a structured interview that assesses satisfaction with various life domains and level of functioning. The reliability of its scales ranges from acceptable to highly acceptable (Cronbach alpha= .56 to .87 on the subscales). In this study, we will only use one item to measure global quality of life: Which of the following best describes how you feel about your life as a whole? (7point scale from Terrible to Delighted). Lehman, A. F. (1998). A

quality of life interview for the chronically mentally ill. *Evaluation and Program Planning, 11*, 51-62.

Hope was assessed using the *State Hope Scale* [SHS]. The SHS measures hopefulness and optimism using 6 items on a 4-point scale, and has an alpha=0.81. Snyder, C.R.; Sympson, S.C.; Ybasco, F.C.; Borders, T.F.; Babyak, M.A.; & Higgins, T.F. (1996). Development and validation of the state hope scale. *Journal of Personality and Social Psychology*, 1996, 70(2), 321-335.

Recovery Markers Questionnaire (Ridgway, P. A., 2005). For this study, we used the *Recovery Markers Questionnaire* which assesses the person's perception of his or her progress in important life domains such as housing, education, employment, and symptom management (24 items).

Additional items including Demographics, and Mental Health Background questions. The items used to collect demographic and mental health background have been used by Mowbray, Bellamy et al in a previous study with over 1000 consumers of mental health services at 60 consumer centered service sites in the state of Michigan (people with a history of serious mental illnesses), and have had success in administering the survey items and with participants answering the questions without any adverse effects. Several papers were published using this data:

Holter, M. C., Mowbray, C. T. Bellamy, C. D., MacFarlane, P. & Dukarski, J. (2004). Critical Ingredients of consumer-run services: Results of a national survey. *Community Mental Health Journal, 40*(1), 47-63.

Mowbray, CT, Bybee, D., Holter, M, & Lewandowski, L. Validation of a Fidelity Rating (2006). Instrument for Consumer-Operated Services, *American Journal of Evaluation, 27*, 9-27.

Bellamy, C. D., Garvin, C., MacFarlane, P., Mowbray, O. P., Mowbray, C. T., & Holter, M. C. (2006). An Analysis of Groups in Consumer-Centered Programs. *American Journal of Psychiatric Rehabilitation, 9*(3), 219-240.

Bellamy, C. D., Jarrett, N. C., Mowbray, O. P., MacFarlane, P., Mowbray, C. T., & Holter, M. C. (2007). Relevance of Spirituality for People with Mental Illness Attending Consumer-Centered Services. *Psychiatric Rehabilitation Journal, 30*(4), 287-294.

Survey packets were distributed to each PeerLink organization to consent participants for data collection.

Sample. In Tennessee, 31 of the 43 PeerLink participants responded to the survey (72.1%). In Wisconsin, 18 of the 83 PeerLink participants responded to the survey (21.7%). Overall, the sample was approximately 44% male (*n* = 21) and 56% female (*n* =27). Sixty-four percent of the participants were White (*n* = 29), 33% (*n* = 15) were African American/Black, and 2% (*n* = 1) were American Indian. Wisconsin, however, had a significantly higher percentage of White/Caucasian persons included in their sample than Tennessee (94.4%, *n* = 17 vs. 44.4%, *n* =

12%). The average age of participants was 44.7 years (*sd* = 13.38); however, Wisconsin had a significantly younger sample than Tennessee (37.9 vs. 50.2 years). Seventy-six percent of the Tennessee sample resided in a group home (*n* = 22), while only 11% of Wisconsin participants lived in a group home (*n* = 2). Group homes for this sample were often fairly institutional, structured environments with a large number of residents. Fifty percent of the Wisconsin sample lived independently, either by themselves or with friends (*n* = 9) versus 14% of the Tennessee sample (*n* = 4).

Most participants had completed high-school or the equivalent thereof (*n* = 29, 63.3%), four persons had some college education (8.2%), and seven persons had graduated college (14.3%). About one-half of the persons in this study were single (*n* = 25, 52.1%). Table 2 contains the demographic data for each of the sites.

Substantial preexisting variations between the Tennessee and Wisconsin cohorts should be taken into consideration when considering the pilot findings, as these differences may have contributed to the final study results. For example, the Tennessee sample included a much higher percentage of African American participants than did the sample from Wisconsin, and, as previously mentioned, the Wisconsin sample was also significantly younger than the Tennessee cohort. Pervasive differences in the treatment and living environments are also important to consider. Tennessee participants were likely to live in large, institutional group homes, while Wisconsin participants were more likely to live independently and, as a result, perhaps have more contacts and relationships akin to peer support before the start of the study. Thus, reported gaps in the degree of improvement between these groups after the PeerLink program may be attributed to the participants' varying points of origin and range of previous exposure to psychiatric and supportive care rather than the intervention alone.

Table 2.

PeerLink Participant Survey Demographics

	Tennessee (N=31) N (%) or Mean (sd)	**Wisconsin (N= 18) N (%) or Mean (sd)**
Education		
< than High School	15 (51.7%)	3 (16.7%)
GED	10 (34.5%)	6 (33.3%)
Voc or Tech. Training	0 (%)	2 (11.1%)
Some College	0 (%)	4 (22.2%)
Graduated College	4 (13.8%)	3 (16.7%)
Race		
White	12 (44.4%)	17 (94.4%)***
African American	14 (51.9%)	1 (5.6%)***
Native American	1 (3.7%)	0 (%)

Table 2.

PeerLink Participant Survey Demographics

	Tennessee (N=31) N (%) or Mean (sd)	Wisconsin (N= 18) N (%) or Mean (sd)
Age (years)	50.2 (12.7)	37.9 (11.1)**
Gender		
Male	13 (43.3%)	8 (44.4%)
Female	17 (56.7%)	10 (55.6%)
Marital Status		
Single	20 (66.7%)	5 (27.8%)
Married	2 (6.7%)	1 (5.6%)
Separated	1 (3.3%)	1 (5.6%)
Widowed	1 (3.3%)	1 (5.6%)
Divorced	5 (16.7%)	7 (38.9%)
In a Relationship	1 (3.3%)	3 (16.7%)
Living Situation		
Group Home	22 (75.9%)	2 (11.1%)
Rooming House	0 (0%)	1 (5.6%)
Staying with Parents	2 (6.9%)	3 (16.7%)
Staying with Friends	0 (%)	2 (11.1%)
Own house or Apt.- ALONE	1 (3.4%)	5 (27.8%)
Own house or Apt.- w/friends	3 (10.3%)	4 (22.2%)
Other	1 (3.4%)	1 (5.6%)
Living Independently	4 (13.8%)	9 (50%)**
Interview Type:		
Self-Administered	6 (46.2%)	3 (27.3%)
Mixed	4 (30.8%)	7 (63.6%)
Interview	3 (23.1%)	1 (9.1%)

Results

Time spent with peer specialists. The majority of persons had been linked with their peer specialist for six months to a year (31, 64.6%). Tennessee participants had more frequent interactions with the peer specialists (66.7%, n = 20 met with peer about once a week) than Wisconsin participants (55.6%, n = 10, met with peer a couple times a month), $p < .01$. Most participants felt that they spent an appropriate amount of time with peers.

In Wisconsin, the majority of persons had been linked with their peer specialist for six months to a year (15, 83.3%). Over half of participants interacted with their peer supporter a couple of

times per month, with 2 persons interacting about once a week and four persons whom interacted with their peer several times a week (11.1% and 22.2% respectively). Most participants felt that they spent an appropriate amount of time with peers and three participants indicated that they desired more time with peers.

In Tennessee, the majority of persons had been linked with their peer specialist for six months to a year (*n* = 16, 53.3%). About two-thirds of participants interacted with their peer supporter about once a week (*n* = 20, 66.7%), with 20% of persons interacting more frequently and 13% persons interacting less frequently with their peer supporter (*n* = 6 and *n* = 4, respectively). Most participants felt that they spent an appropriate amount of time with peers.

Table 3 contains details about the length and frequency of interactions with peers at both sites.

Table 3.

PeerLink Peer Specialist Contact

	Tennessee (n = 31)	**Wisconsin (n = 18)**
Length of time linked to Peer Specialists		
A few weeks	2 (6.7%)	0 (0%)
One month	2 (6.7%)	0 (0%)
Two months	2 (6.7%)	1 (5.6%)
Five months	8 (26.7%)	2 (11.1%)
Six months to < 1 year	16 (53.3%)	15 (83.3%)
Frequency of interaction with peer supporter?		
Every day of the week	0 (0%)	0 (0%)
Several times a week	6 (20%)	4 (22.2%)
About once a week	20 (66.7%)	2 (11.1%)**
A couple times per month	4 (13.3%)	10 (55.6%)**
Other	0 (0%)	2 (11.1%)
Perceptions about amount of time spent with peer specialist		
Too much time	1 (3.4%)	0 (0%)
The right amount of time	25 (86.2%)	15 (83.3%)
Not enough time	3 (10.3%)	3 (16.7%)

Reasons for working with peer specialist. Participants were asked to indicate on a 3-point scale several different reasons why they were working with their peer specialist. The major reasons for Tennessee participants were to learn about recovery and mental health (*n* = 24, 85.7%) and

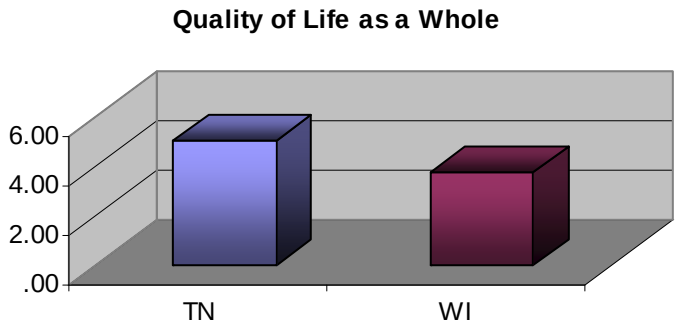
to work on his/her recovery plan (*n* = 24, 85.7%). Tennessee participants indicated that they worked with their peer specialists for more instrumental reasons (help finding a job, help finding a place to live, to learn about community resources) than Wisconsin participants, $p < .01$. The highest rated reason for working with peers for the Wisconsin participants was to get support from someone with similar experiences (*n* = 17, 94.4%), followed by finding out about other community resources and to talk about problems or challenges (*n* = 15, 83.3% for both items). Table 4 contains item-level responses to each of the reasons for working with the peer specialist sorted by domain (support, instrumental, alternative).

Table 4.

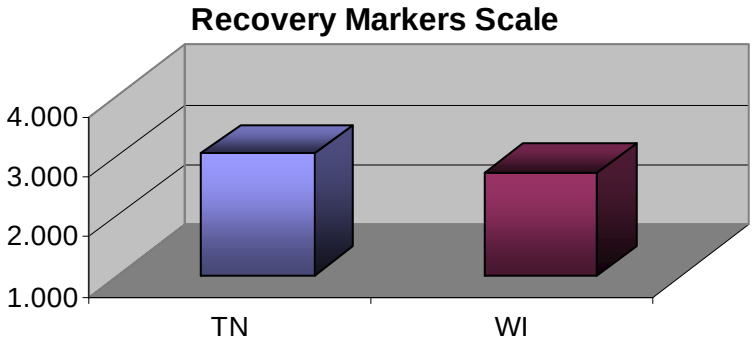
Reasons for working with peer specialist

	Tennessee (n= 31)			Wisconsin (n = 18)		
	Yes n (%)	No n (%)	Sometimes n (%)	Yes n (%)	No n (%)	Sometimes n (%)
Supportive Reasons	Mean (sd) = 1.46 (.59)			Mean (sd) = 1.47 (.36)		
To get support from someone with similar experiences	21 (75%)	5 (17.2%)	2 (7.1%)	17 (94.4%)	0 (0%)	1 (5.6%)
To talk to about problems or challenges	20 (71.4%)	6 (21.4%)	2 (7.1%)	15 (83.3%)	1 (5.6%)	2 (11.1%)
To socialize	20 (71.4%)	3 (10.7%)	5 (17.9%)	12(66.7%)	5 (27.8%)	1 (5.6%)
To attend support groups	17 (58.6%)	11 (37.9%)	1 (3.4%)	5 (29.4%)	10 (58.8%)	2 (11.8%)
Instrumental Reasons	Mean (sd) = 1.43 (.43)			Mean (sd) = 1.08 (.46)**		
To find out about other community resources	23 (79.3%)	5 (17.2%)	1 (3.4%)	15 (83.3%)	3 (16.7%)	0 (0%)
To work on his/her recovery plan	24 (85.7%)	4 (14.3%)	0 (0%)	14 (77.8%)	2 (11.1%)	2 (11.1%)
To learn about recovery and mental health	24 (85.7%)	3 (10.7%)	1 (3.6%)	11 (61.1%)	3 (16.7%)	4 (22.2%)
To learn about discussion groups and other classes	22 (75.9%)	6 (20.7%)	1 (3.4%)	8 (44.4%)	4 (22.2%)	6 (33.3%)
To learn more about WRAP	19 (70.4%)	8 (29.6%)	0 (0%)	9 (52.9%)	7 (41.2%)	1 (5.9%)
To learn about advocacy	16 (59.3%)	9 (33.3%)	2 (7.4%)	6 (35.3%)	7 (41.2%)	4 (23.5%)
To get help to find someplace to live	16 (57.1%)	11 (39.3%)	1 (3.6%)	4 (23.5%)	12 (70.6%)	1 (5.9%)
To get help finding a job	15 (53.6%)	12 (42.9%)	1 (3.6%)	1 (5.9%)	15 (88.2%)	1 (5.9%)
Alternative Reasons	Mean (sd) = .5 (.57)			Mean (sd) = .32 (.58)		
Because someone else made him/her	7 (25.9%)	20 (74.1%)	0 (0%)	4 (22.2%)	14 (77.8%)	0 (0%)
Because he/she has nothing else to do	6 (20.7%)	21 (72.4%)	2 (6.9%)	2 (11.8%)	14 (82.4%)	1 (5.9%)

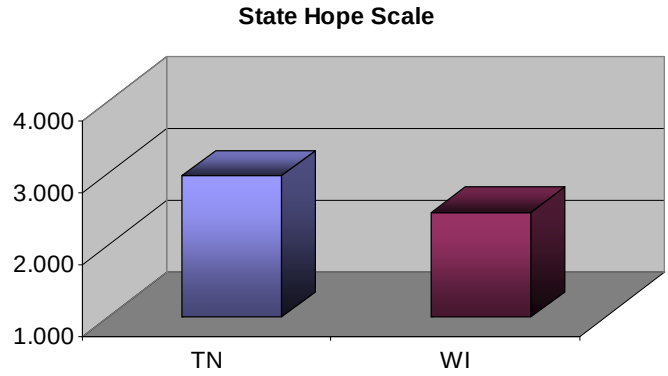
Quality of Life. Quality of life was assessed by a single item that asked individuals to indicate how they felt about their lives as a whole on a 7-point rating scale (1 = terrible and 7 = delighted (Lehman, 1988). Across both sites, three persons reported being delighted (6.4%), and two reported feeling terrible (4.3%), with the rest of participants falling in between the two extremes. There was a significant difference ($p < .01$) between sites with Tennessee having a mean quality of life score of 5.03 (*sd* = 1.88) and Wisconsin a mean of 3.76 (*sd* = 0.97).



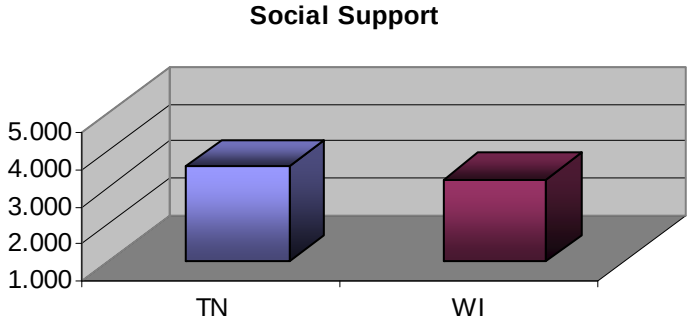
Recovery. Recovery was assessed by the 28-item Recovery Markers Scale (Ridgway, unpublished). Respondents are asked to rate 23 items on a four-point Likert scale that persons with lived experience of mental health issues have articulated as essential components of recovery (e.g., feeling safe in home, good physical health, connections with others). There are five additional yes/no items assessing employment and participation in school. A total score was calculated for each participant and the means of the total scores on this measure were compared between the sites. The mean recovery score was 2.89 (*sd* = .40) across both sites; however Tennessee participants had significantly higher Recovery Markers scores (*M* = 2.99, *sd* = 0.36) than Wisconsin participants (*M* = 2.72, *sd* = 0.42), $p < .05$.



Hope. The State Hope Scale is a six item scale measuring the degree to which individuals believe they can pursue and accomplish their goals and handle adversity (Snyder, 1996). The mean score was 2.76 (*sd* = .73) with Tennessee having a significantly higher state hope score (*M* = 2.97, *sd* = 0.69) than Wisconsin (*M* = 2.46, *sd* = 0.71), $p < .05$.



Social Support. Social support was measured by using the 14-item Social Support Questionnaire (Norbeck, et al. 1981). This measure assesses the degree to which respondents feel as if they have people in their lives that they can rely on for emotional support. The mean Social Support score was 3.42 (*sd* = .73) with no significant difference between sites.



Mental Health Confidence. Mental health confidence and self-efficacy was measured using the 16-item Mental Health Confidence Scale (Carpinello et al., 2000). The mean score was 4.02 (*sd* = .91), with Tennessee participants having significantly higher mental health confidence scores (*M* = 4.24, *sd* = 0.87) than Wisconsin participants (*M* = 3.68, *sd* = 0.88), $p < .05$.

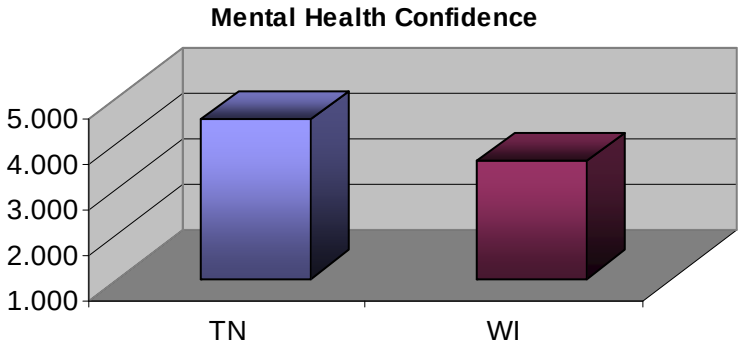


Table 5.
PeerLink Outcomes

	Tennessee (n = 31)	Wisconsin (n = 18)
Quality of Life	5.03 (1.88)	3.76 (0.97)**
Recovery Markers Scale	2.99 (0.36)	2.72 (0.42)*
Not working, but see self working in 6 months	10 (34.5%)	3 (17.6%)
Working part-time	1 (3.6%)	3 (17.6%)
Working full-time	1 (3.6%)	2 (11.8%)
Not currently seeking employment	11 (39.3%)	8 (47.1%)
In school	2 (7.1%)	1 (6.3%)
State Hope Scale	2.95 (0.69)	2.46 (0.71)*
Social Support Questionnaire	3.51 (0.69)	3.27 (0.77)
Mental Health Confidence Scale	4.24 (0.87)	3.68 (0.88)*

Self-Reported Service Utilization. Over the course of the thirty days prior to the interview, eight persons (16.3%) reported using emergency psychiatric services and eleven persons (22.9%) reported being hospitalized for mental illness. The mean number of times a person reported seeing a doctor regarding mental health medications within 30 days prior to their interview was 2.61 (*sd* = 4.87).

In the sample as a whole, forty-two persons (89.4%) had a case manager or therapist; eight persons (17%) reported attending substance abuse self-help groups and nine persons (19.1%) reported attending self-help/support groups. Seventeen persons (37%) reported that they did not need any mental health services in the past 30 days and 21 (45.7%) reported needing mental health services a little. Thirty-four persons (70.8%) reported a current or past drug or alcohol problem. Six persons (12.5%) reported receiving help for an alcohol or drug problem within the thirty days prior to their interview,

Twenty-two persons (46.8%) reported no hospitalizations for mental illness within the 6 months prior to their interview, 13 (27.7%) reported being hospitalized once, six (12.8%) reported being hospitalized twice, and six (12.8%) reported being hospitalized three or more times.

For Wisconsin, over the course of the thirty days prior to the interview, as reported on the survey, five persons (27.8%) used emergency psychiatric services and five persons (27.8%) had been hospitalized for mental illness. The mean number of times a person had seen a doctor regarding mental health medications within 30 days prior to their interview was 1.78 (*sd* = 2.42). Thirteen persons (72.2%) had a case manager or therapist; two persons (11.1%) reported attending substance abuse self-help groups and one person (5.6%) reported attending self-help/support groups. Three persons (16.7%) reported that they did not need any mental health

services in the past 30 days, nine persons (50%) reported needing mental health services a little and six persons (33.3%) reported needing services a lot. Three persons (16.7%) reported being in recovery from an alcohol or drug problem and two persons (11.1%) reported receiving help with a substance abuse problem within the three months prior to their interview. Five persons (27.8%) reported no hospitalizations for mental illness within the six months prior to their interview, eight (44.4%) had been hospitalized once, two (11.1%) had been hospitalized twice, and three (16.7%) had been hospitalized three or more times.

For Tennessee, over the course of the thirty days prior to the interview, as reported on the survey, three persons (10%) used emergency psychiatric services and six persons (20%) had been hospitalized for mental illness. The mean number of times a person had seen a doctor regarding mental health medications within 30 days prior to their interview was 3.19 (*sd* = 5.99). Twenty-nine persons had a case manager or therapist; six persons (20.7%) reported attending substance abuse self-help groups and eight persons (27.6%) reported attending self-help/support groups. Fourteen persons (50%) reported that they did not need any mental health services in the past 30 days and 12 (42.9%) reported needing mental health services a little. Four persons (13.3%) reported receiving help for an alcohol or drug problem within the ninety days prior to their interview. Seventeen persons (58.6%) self-reported no hospitalizations for mental illness within the six months prior to their interview, five (17.2%) had been hospitalized once, four (13.8%) had been hospitalized twice, and three (10.3%) had been hospitalized three or more times.

Table 6. Self-Reported Service Utilization

	Tennessee (n = 31)	**Wisconsin (n = 18)**
Service Utilization		
Used emergency psychiatric services/ past 30 days	3 (10%)	5 (27.8%)
Hospitalized for mental illness/ past 30 days	6 (20%)	5 (27.8%)
Number times see doctor re: mental health medications/ past 30 days	3.19 (5.99)	1.78 (2.42)
Have a case manager or therapist	29 (100%)	13 (72.2%)**
Number times see case manager or therapist/ past 30 days	3.88 (6.06)	2.33 (3.53)
Regularly go to AA, NA, or similar meetings.	6 (20.7%)	2 (11.1%)
Regularly go to self-help/support groups?	8 (27.6%)	1 (5.6%)†
Need for mental health services/past 30 days		
Not at all	14 (50%)	3 (16.7%)**
A Little	12 (42.9%)	9 (50%)
A Lot	2 (7.1%)	6 (33.3%)
Drug/alcohol problem (other perception)	10 (33.3%)	7 (38.9%)

Table 6. Self-Reported Service Utilization

	Tennessee (n = 31)	Wisconsin (n = 18)
Drug/alcohol problem (self-perception)	3 (10%)	3 (16.7%)
In recovery from alcohol or drug problem	8 (26.7%)	3 (16.7%)
Help with alcohol or drug problem/ past 3 months	4 (13.3%)	2 (11.1%)
How much follow case manager or therapist advice		
Not at all	1 (3.3%)	0 (0%)
A little	11 (33.7%)	8 (44.4%)
A lot	18 (60.0%)	10 (55.6%)
How much case manager or therapist helps		
Not At All	2 (7.1%)	0 (0%)
A Little	9 (32.1%)	7 (38.9%)
A Lot	17 (60.7%)	11 (61.1%)
Number of times hospitalized for mental health problems/ past 6 months		
0	17 (58.6%)	5 (27.8%)
1	5 (17.2%)	8 (44.4%)
2	4 (13.8%)	2 (11.1%)
3 or more	3 (10.3%)	3 (16.7%)

Relationship between peer interaction variables and outcomes controlling for demographic variables. The relationship between site and peer interaction variables was further assessed controlling for race, age, and independent living situation to determine if individual demographic variables were accounting for some of the differences in frequency, length of time, or reasons for working with peers (Table 7). Appendix A contains an intercorrelation matrix of all variables. After controlling for these demographic variables, we found a trend ($p < .10$) for Wisconsin participants to be working longer with their peer specialist than Tennessee participants.

Table 7. Peer Interaction Variables controlling for race, age, and independent living situation

	TN	WI	
	Mean (sd)	Mean (sd)	B
Length of time with peer specialist	4.18 (.24)	4.92 (.25)	-.75†
Frequency of Interaction	2.98 (.22)	2.58 (.22)	.40
RTC- Instrumental	1.42 (.11)	1.15 (.12)	.27
RTC- Support	1.43 (.11)	1.59 (.11)	-.16
RTC- Other	.51 (.12)	.22 (.15)	.29

Controlling for age, race, and independent living situation
† p<.10

In Wisconsin, there is a relationship between age and length of time working with peer specialists, with older participants reporting longer time working with their peer specialist. In Tennessee, there was a relationship between gender and frequency of interaction with a peer specialist, with women reporting more interaction.

The relationship between peer interaction variables and recovery outcome variables was then assessed controlling for all demographic differences between sites to see if the individual differences between sites on these domains accounted for the differences in recovery outcomes. Linear mixed model regression analyses were used to measure the effect of length of time working with peer, frequency of interaction with peer, and instrumental reasons to come on certain outcome variables above and beyond those variables that were held constant (Table 8).

Table 8.

Relationship between peer interaction variables and recovery outcomes

	Length of time working with peer	Frequency of interaction with peer	Instrumental Reasons for working with peer	TN	WI	State
	Beta	Beta	Beta	Mean (se)	Mean (se)	Beta
Recovery Markers Scale	-.02	-.02	.38*	3.04 (.11)	2.73 (.12)	.31
State Hope Scale	.04	-.08	.85*	3.0 (.21)	2.46 (.22)	.53

Table 8.

Relationship between peer interaction variables and recovery outcomes

	Length of time working with peer	Frequency of interaction with peer	Instrumental Reasons for working with peer	TN	WI	State
	Beta	Beta	Beta	Mean (se)	Mean (se)	Beta
Social Support	-.24	-.29	.24	3.55 (.21)	3.21 (.22)	.34
Mental Health Confidence	.31†	-.13	.69†	4.23 (.23)	3.62 (.24)	.91*
Used ER Psych/30 days	-.69	.33	3.68	-.03 (.10)	.51 (.11)	-5.15*
MH hospitalization/ 30 days	.05	.12	2.18	.03 (.10)	.38 (.11)	-3.10
# times see doc. Re: meds/30 days	-4.38***	.18	.44	1.52 (1.22)	4.13 (1.22)	-2.61
Have c/m or therapist	-.04	.14	-.12	.98 (.10)	.79 (.11)	.18
# times see cm or therapist	-4.10***	.65	-2.01	2.19 (1.41)	4.40 (1.41)	-2.21
Attend SA self-help group	-1.03†	1.04	-.34	.07 (.09)	.06 (.10)	-.24
Attend MH self-help group	-.24	1.48†	-.32	.14 (.11)	.09 (.11)	.45
Need for MH services	-.14	.20	.07	1.54 (.19)	2.25 (.20)	-.71*
Alcohol/drug problem – other perception	-.79	-.57	-.59	.30 (.16)	.51 (.21)	-.88
Alcohol/drug problem – self perception	.05	-.01	.01	.08 (.10)	.14 (.10)	-.06
In recovery from alcohol or drugs	.62	-1.57	-.73	.08 (.09)	.13 (.15)	-.53
Help for problem with alcohol/drugs	.03	-.04	.28*	.10 (.08)	.13 (.09)	-.03
Follow c/m advice	-.05	.04	.40	1.60 (.15)	1.62 (.16)	-.02
How much c/m help?	.04	.19†	-.04	1.77 (.13)	1.56 (.14)	.21
#MH hospitalizations/6 months	-.29	.51*	.39	.38 (.26)	1.40 (.28)	-1.03*
Quality of Life	.00	-.03	1.16	4.74 (.43)	3.82 (.47)	.93

Controlling for age, race, independent living situation, length of time working with peer, frequency of interaction with peer, and instrumental reasons for working with peer

† p<.10, * p<.05, ** p<.01, *** p<.001

Results of the linear mixed regression models indicate that individuals who worked with their peers for more instrumental reasons had significantly higher scores on the Recovery Markers Scale ($p < .05$) and State Hope Scale ($p < .05$), and higher self-reported need for help with an

alcohol or drug problem ($p < .05$), than individuals who worked with peers primarily for other reasons. This suggests that the activities that the peers do together and the type of support received by the program is an important dimension in individual recovery.

Participants who had worked for longer lengths of time with their peer at the time of the survey reported seeing their doctor and their case manager or therapist significantly less than those who had worked with their peer for shorter periods of time ($p <.001$ for both comparisons). Frequency of interaction with peer was also significantly and positively related to the number of hospitalizations the participants reported in the past 6 months ($p < .05$). However, caution should be used in interpreting these findings as the survey was a single point in time and therefore patients were at different stages in their recovery when the survey was given.

Evaluation Study 3: Participant Focus Group

Design/Sample. Focus groups with participants were scheduled at each site by Yale researchers. Each site was given a flyer and asked to recruit participants. There were 3 participants in Wisconsin and 6 participants in Tennessee that attended the focus group. The focus group session was tape recorded, transcribed and analyzed by research assistants. The following questions were used to guide the discussion: 1). Please share with us how you became involved with the PeerLink project; 2). What was it like to have peer specialists?; 3). What would you say are the most helpful things that you and your peer specialist have worked on together?; 4). What are some of the highlights of your experience with PeerLink?; 5). What would you describe as some of the challenges of the PeerLink project?; and, 6). What are some ways in which the PeerLink project can be improved?

Results. Data gathered in focus groups shed light on the important subjective qualities of the peer relationship that might have contributed to these positive outcomes. Overall, participants spoke highly of their experience with peer support specialists, often gesturing towards less quantifiable benefits reaped from the program. Many expressed their appreciation for having someone to talk to who genuinely cared for them and was willing to listen. One individual praised a peer supporter as “a good listener, not like a lot of people who just rush you through.” Many described experiencing personal growth as a result of the program that encompassed a greater degree of “focus”, sharper “vision,” augmented sense of hope, and “increased…self-esteem,” stemming in part from “positive affirmation” received.

Trust, and the peer specialists’ skillful balancing of friendship and structured support also factored into the positive experiences of many participants. One individual said that his peer mentor was someone to “trust and count on. Yes. He’s like a friend, you can sit around and shoot the breeze but when it’s time to get to business, it’s time, and he’s there too. He makes the best out of everything we do.” Another compared his or her peer specialist to people on the street, saying “I can really trust him, you can’t put trust in a lot of people on the street…It’s hard to find a good friend.”

The program seemed to foster the development of concrete personal goals in the wake of difficulties, rather than what some participants described as the chaos and distress they tended to associate with care as usual. One individual said, "There are things I talk about here that you know, upset me sometimes, but it seems like I can talk and get a resolution, I get a plan. That's what makes a difference." Others spoke of the practical support they got from peers in advocating for various issues or locating services, such as dental care or housing. One participant proudly identified tangible milestones reached as a result of peer support:

> I feel like hope is what gets us to get into recovery and to stay in recovery and this knowledge is what will help to anchor me. The knowledge that I've gained is powerful because there is so much that I thought I knew but didn't know. And with each class I learned and connected the dots…I have a presentation at Ladies Inspiration Day about women and depression and I told them that these classes gave me the courage to do that. I know that this program gave me the courage to do this.

Significantly, individuals pointed out that peer supporters were able to provide distinct services based on their lived experiences. One participant mentioned that a peer supporter had "been in the same position as I've been. She's able to share how she dealt with it and is able to share her experience. Been there done and done that." Another attributed the decision to participate in the study to "knowing that they had the same issues; it could be somebody that knew about mental health."

Finally, information gathered in focus groups points to the notion that something specific to the peer relationship might have contributed to the significant finding that PeerLink involvement correlated with decreased hospitalizations. One participant expressed an ability to "really talk to them the way I want to." Because of this openness, this person explained that "they really bring out how I really feel. They understand that I'm just having a bad day while providers might want to send me to the hospital." Others said that coming in, meeting with a peer, and getting feedback was the key ingredient preventing hospitalization.

Evaluation Study 4: OptumHealth Staff Online Survey

Design. A survey was created and designed by the collaborative team for the evaluation project. An on-line survey was conducted using Survey Monkey. The link to the survey was emailed by OptumHealth to 25 staff connected with the PeerLink project. The survey participants were told the purpose of the survey was to identify both the challenges and successes of the PeerLink project.

Sample. Of the seventeen service staff, 13 (76.5%) were administrators and 4 (23.5%) were full-time clinical providers. A large majority of staff had been with the company less than 5 years (14, 82.4%). Females represented a larger proportion of staff than male (12, 70.6%; 5, 29.4%, respectively) and the majority of staff were White/Caucasian (12, 70.6%).

Results. Fifty percent of staff referred 6 or more clients to PeerLink. Six staff members (35.3%) reported that clients had indicated the PeerLink had been helpful, three staff (17.6%) were unsure, and eight staff (47.1%) did not find the question applicable. Seventy one percent of staff members indicated that they believed PeerLink should be expanded throughout the state and four staff were unsure or did not know.

Table 9.

OptumHealth Staff Survey

	N (%)
Type of Position	
-Administration	13 (76.5%)
-Full Time Clinical Provider	4 (23.5%)
Number of Years with Company	
-Less than 5	14 (82.4%)
-5-10 years	2 (11.8%)
-More than 10	1 (5.9%)
Gender	
-Male	5 (29.4%)
-Female	12 (70.6%)
Race	
-Black/African-American	5 (29.4%)
-White	12 (70.6%)
Number of Clients referred to PeerLink	
-0-5	8 (50%)
-6-10	1 (6.3%)
-11-15	3 (18.8%)
-16-20	1 (6.3%)
-more than 20	3 (18.8%)
Clients have indicated that PeerLink has been helpful	
-Not sure/ Don't know	3 (17.6%)
-Agree	4 (23.5%)
-Strongly Agree	2 (11.8%)
-N/A	8 (47.1%)
PeerLink should be expanded throughout the state	

Table 9.

OptumHealth Staff Survey

	N (%)
-Not sure/Don't know	4 (23.5%)
-Agree	5 (29.4%)
-Strongly Agree	7 (41.2%)
-N/A	1 (5.9%)

Responses to open-ended questions. OptumHealth staff survey participants provided responses to the following questions: Please tell us briefly about your experiences working with Peer Specialists in your state; What were some of the challenges in working with the PeerLink project? and, Please provide suggestions for how to improve upon these challenges to strengthen the PeerLink project?

Overall respondents reported positive experiences in working with the peer specialists:

> "I find that working with Peer Specialists can be a rewarding and enriching process. Peer to Peer connections are very helpful to finding the path to recovery."
>
> "My experience has been positive working with the peer specialists. When interacting with them, they have demonstrated a true compassion for the job they are set out to do…."
>
> "Overall I can certainly see the benefits of the PeerLink program, particularly if all components are up and running smoothly in the future. It certainly is a resource that has made a difference already, but could potentially significantly impact the lives of our members who suffer from lack of engagement in community based resources."

Several of the respondents spoke to challenges in implementation such as, ***the pilot should have been longer to allow more time for referrals***: *"there seemed to be some lag time between the referral and actual contact with the clients, although there were several variables that may have contributed to the lag…."* One respondent stated *"Our point person will not accept referrals by secure email, only fax which is far more time consuming. No communication to let us know which members are receiving services"*. Another respondent indicated a concern of whether referrals were being made by the providers to the PeerLink project. Another challenge indicated was ***connecting members to the program after they were discharged*** because members' contact information had changed (phone numbers, addresses). Once connected, some respondents indicated there was ***no formal process of knowing whether the clients were receiving the service***. One respondent stated that the ***pool of members being recruited to the program was too small for the pilot***: *"Another challenge to getting the original desired number of participants enrolled in the program was the number of original identified pool of members*

was too small. There were 50 members identified with the expectation that 50 would enroll. That was not a realistic pool given some of the already stated barriers. Perhaps if a larger number of possible candidates could have been identified, more members may have agreed to participate." Respondents also stated that there was a ***lack of acceptance by the Medicaid provider network and the subcontracted organizations*.** Additional challenges were described by respondents related to service providers: *"It appeared when individuals began to show improvement the staff at the homes would pull them out of the program or throw up additional barriers".*

Suggestions for improving challenges included:

- **education and marketing**: *"better education provided to the providers of mental health services to get a more positive "buy in" into the process for referrals and understanding that PeerLink was a support to the member, not a replacement for the services the member was getting from that provider"* – Suggestion was to have "buy-in" from the top and a community stakeholder meeting earlier in the implementation process;
- **connection by peer specialists prior to discharge from the hospital**;
- **ongoing supervision, training and mentoring for peer specialists**;
- **user friendly referral process and a list of members' receiving services**; and,
- **peer organizations having ability to contract with a variety of payers to ensure service continuity.**

Evaluation Study 5: Peer Specialist Focus Group

Design. Peer specialists from both sites were invited to a focus group. A telephone focus group method was used. Krueger (2011) described the use of the telephone focus group method as having several benefits, including: greater participation opportunities for individuals with busy schedules; increased ability to focus and speak one at a time, usually following general telephone etiquette principles; and a general tendency for participants to feel less threatened because they are not able to see each other. On the other hand, the phone method can also be a disadvantage because participants cannot see each other's nonverbal cues and they cannot visually connect with each other (which may have been a particular bonus in this case given the dual-site nature of the project). In the end, however, it was decided that this method would be most beneficial since it would allow for the most people to participate in the discussion at one time.

Facilitators used six questions to lead the discussion and collect data regarding the peers' experiences participating in PeerLink. The questions were: (1) please tell us how you became involved with the PeerLink project; (2) please provide an example or a story of success in working with a PeerLink participant; (3) what aspects of the training received wither before or during PeerLink were useful in helping you do this work?; (4) what additional training needs do you have or that might benefit others running a PeerLink project?; (5) please share examples of

what you have learned about yourself doing this work. How has the project benefited you personally?; (6) if you could change one thing about the PeerLink project, what would it be?

Sample. Seven Peer specialists from both Wisconsin and Tennessee participated in a telephone focus group session led by two Yale researchers.

Results. Six major themes emerged from this focus group. First, many peers discussed the importance of **listening to** and being there for someone. One person stated that, "It was important to listen to their needs and make myself available… [the participant] could see the light at the end of the tunnel. Talking to me made all the difference in the world".

Second, the peers' role in helping participants reach their **dreams and goals** through support and education emerged as a key theme. One peer talked about how they helped others recognize their strengths and worked to re-frame mental health difficulties as gifts that, "can be used for something good."

Third, Peers regarded the ability to **maintain flexibility** in Peer work as crucial to avoiding burnout. Within the framework of this third theme, they talked about the difficulty of maintaining contact with participants. Some mentioned that they had to work to balance an understanding of the fact that people had to juggle complex lives with many issues while simultaneously remaining persistent in their efforts at engagement. Peers felt that it was important for them to respect a person's place in recovery as well as their life difficulties while also working diligently to establish a mutual and beneficial relationship.

Fourth, participants focused on the significance of **doing with not for. It was important for Peers to** set boundaries and help people learn how to cope and deal with obstacles on their own. One peer stated that "people can become dependent on us. We want them to be able to maneuver on their own". Many saw it as their role to offer support and guidance on how to deal with obstacles, but not to take charge of participants' lives. They were conscious of their desire to be helpful by "doing," but first and foremost wanted to enable participants to take charge of their own recovery.

Fifth, many saw the process of engaging in peer work **as a means of enhancing their own recovery.** Many talked about how being a peer increased their self-esteem and self-worth. One peer said that, "I am worth more than I thought… [this work] gave me a greater sense of purpose than before." Another said, "It gave me a reason to be grateful for my life." Finally, researchers identified **continued self-care** as the sixth important theme. Peers regarded their ability to set boundaries for themselves as critical since this allowed them to prioritize their own recovery. Peers talked about the need to take care of themselves so that they could, "be available when [they] need[ed] to." More extensive selected quotations by peers around these themes are located in Appendix B.

Peer specialists also provided some suggestions for *OptumHealth* or other programs using the *PeerLink* model. Most of their recommendations centered on training needs for peers and ways

in which programs might connect more people in recovery (peer participants) with programs. Peers recommended offering trainings in "Building Sanctuary", "Cultural Diversity", and "Illness Recovery Management." Suggestions for recruitment and engagement included providing peer specialist services to all individuals discharged from inpatient and outpatient programs in an attempt to make peer services more readily available as part of a treatment plan. Others recommended that practitioners offer peer services not only for those who have been hospitalized but more to patients more broadly. Peers also suggested providing transportation for all peer participants since this proved to be a challenge for successful implementation of the program. Additional quotations offering suggestions for PeerLink are located in Appendix B.

Conclusions and Limitations

These preliminary observational findings shed some light on some essential components and benefits of the implementation of PeerLink services. On average, participants had worked with their peer specialists for over 4 months, and had an average of 16 contacts with them. The major reasons for working with their peer specialist were to learn about recovery and mental health, to work on member's recovery plan, and to get support from someone with similar experiences. In Tennessee, learning about recovery and mental health and working on their recovery plan were the major reasons indicated for working with peer specialists. In Wisconsin, support from someone with similar experiences, followed by finding out about community resource and to talk about problems or challenges were the major reasons.

At the time of the survey, participants reported positive outcomes on measures of quality of life, recovery markers, state hope, social support, and mental health confidence. Results suggest that individuals who worked with their peer specialists for instrumental reasons had significantly higher scores on the Recovery Markers Scale and State Hope Scale, and higher self-reported need for help with an alcohol or drug problem, than individuals who worked with peers primarily for other reasons. This suggests that the activities that the peers do together and the type of support received by the program is an important dimension in individual recovery. It also suggests that continuation of a peer person-centered approach should allow the peer specialists more effective ways of working to directly address the needs and concerns of individuals.

The qualitative findings support some of the quantitative data. Focus group data revealed several key themes amongst participants. Individuals generally reported that they gained increased self-confidence and that the program instilled in them a focus on goals and a clearer sense of vision. They also expressed feeling more hopeful as a result of the program. In addition to these more abstract benefits, participants pointed towards practical assistance gained from peers, assistance that was distinctive because it came from someone with experience with mental illness; Participants reported that they felt a sense of trust, support, and genuine understanding from those who had similar journeys. Finally, individuals reported that peer support proved instrumental in helping them stay out of hospitals. Participants felt they were

able to connect in a “real” way with peer specialists about their experiences; that peers offered hope and positive affirmation; and, that peers offered practical support.

Differences between Wisconsin and Tennessee should be interpreted with caution as there were significant differences in types of services offered (face-to-face vs. telephonic), how those services were delivered (individually vs. a group setting), and how services were tracked by the peer program (Wisconsin staff tracked all contact between peers (e.g. short phone calls, which likely brought down the median time of conversation)), while Tennessee did not record data on this sort of outreach). Also, as previously discussed, preexisting demographic and living situation differences between states could have impacted results

In addition, limited conclusions can be drawn relating utilization of behavioral health services (e.g. hospitalization, medication visits) and peer support received, as both were self-reported and at a single point in time (vs. being administered to participants at a set time in their program participation such as 6 months after they enrolled). Participants were therefore at different stages of recovery at the time of the survey and had varying opportunity to experience time with their peers.

Several barriers to providing peer services emerged from data gathered via both quantitative and qualitative methods. Homelessness, an issue singled out by individuals in Wisconsin, proved to be a substantial challenge for many. Transportation also emerged as a considerable obstacle for those in Wisconsin; because peer providers were not able to use their cars and participants often had no access to vehicles, arranging meetings could be difficult. Providers in Tennessee often had difficulty contacting and locating participants, thus interfering with program implementation.

Despite these barriers, however, both OptumHealth staff and Peer Specialists reported positive experience with the peer program, and had suggestions for ways to improve the program in the future. For example, OptumHealth staff suggested more education and “buy-In” from community stakeholders to improve program implementation, and Peer Specialists suggested more expanded training, and to consider offering peer services beyond just a previously hospitalized population.

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Appendix A. Correlation Matrix between Peer Interaction Variables, Demographics, and Outcomes

	Length of time with peer specialist		Frequency of interaction		Reasons to work with peer specialist: Instrumental		Reasons to work with peer specialist: Support		Reasons to work with peer specialist: Other	
	TN	WI	TN	WI	TN	WI	TN	WI	TN	WI
Age	0.14	.559*	0.40	-0.19	0.04	-0.22	0.35	0.09	-0.32	-0.14
Female	0.04	-0.37	.454*	-0.29	0.09	-0.02	0.13	-0.31	0.07	-0.05
Independent Living	0.28	-0.21	-0.05	-0.35	0.05	-0.46	0.18	-0.32	-0.11	0.02
White	-0.05	-0.10	0.14	0.11	0.14	-0.31	-0.02	-0.02	-0.04	-0.08
Married	0.10	0.20	0.00	-0.10	-0.16	-0.47	0.19	0.07	-0.26	-0.28
Quality of Life	0.36	0.01	0.34	-0.07	0.33	-0.20	0.37	0.14	0.00	.599*
Length of time with peer specialist	1.00	1.00	0.23	-0.02	0.17	0.08	.539**	0.12	-0.24	0.25
Frequency of interaction	0.23	-0.02	1.00	1.00	0.25	.516*	0.37	.655**	-0.16	-0.34
Reasons to Come-Instrumental	0.17	0.08	0.25	.516*	1.00	1.00	.630**	.633**	0.26	-0.09
Reasons to Come-Support	.539**	0.12	0.37	.655**	.630**	.633**	1.00	1.00	-0.07	-0.13
Reasons to come- Other	-0.24	0.25	-0.16	-0.34	0.26	-0.09	-0.07	-0.13	1.00	1.00
Recovery Markers Scale Total	0.02	-0.31	0.24	0.04	.607**	0.16	.454*	0.38	0.23	0.14
State Hope Scale Total	-0.01	0.02	0.21	-0.09	.502*	0.09	0.22	0.21	0.35	.499*
Social Support Questionnaire Total	0.00	-0.37	-0.08	-0.37	0.22	-0.08	0.17	-0.13	0.28	0.27

Appendix A. Correlation Matrix between Peer Interaction Variables, Demographics, and Outcomes

	Length of time with peer specialist		Frequency of interaction		Reasons to work with peer specialist: Instrumental		Reasons to work with peer specialist: Support		Reasons to work with peer specialist: Other	
	TN	WI	TN	WI	TN	WI	TN	WI	TN	WI
Mental Health Confidence Scale	0.33	0.24	0.36	-0.23	.537**	0.18	.589**	0.17	0.12	0.31
Used emergency psychiatric services/30 days	-0.04	0.03	0.15	0.23	0.28	0.46	0.12	0.31	-0.32	-0.03
Mental Health hospitalization/30 days	-0.19	0.03	-0.20	0.23	-0.22	0.46	-0.33	0.31	-0.25	-0.03
# times see psych doc re: meds/30 days	-.665**	0.05	0.10	0.02	-0.01	0.34	-0.28	0.09	0.18	-0.02
have c/m or therapist	.[a]	-0.26	.[a]	0.16	.[a]	-0.09	.[a]	-0.14	.[a]	-.539*
# times see cm or therapist/30 days	-.608**	0.16	0.03	0.02	0.08	-0.40	-0.20	0.01	0.25	-0.23
attend SA self-help group	-0.32	0.15	-0.03	.575*	-0.22	0.24	-0.12	.529*	-0.10	-0.14
attend MH self-help group	-0.24	0.10	0.10	0.39	-0.06	0.24	0.02	0.36	-0.18	-0.14
need for mh services	-0.27	-0.05	-0.06	0.06	-0.16	0.32	-0.34	-0.21	0.13	-0.13
alcohol/drug problem-other perception	-0.25	0.12	0.04	-0.25	-0.11	0.04	-0.05	-0.26	-0.27	0.34

Appendix A. Correlation Matrix between Peer Interaction Variables, Demographics, and Outcomes

	Length of time with peer specialist		Frequency of interaction		Reasons to work with peer specialist: Instrumental		Reasons to work with peer specialist: Support		Reasons to work with peer specialist: Other	
	TN	WI	TN	WI	TN	WI	TN	WI	TN	WI
alcohol/drug problem-self-perception	-0.04	0.19	-0.04	0.10	-0.18	0.24	-0.03	0.25	-0.32	-0.05
in recovery from alcohol/drugs	0.18	0.19	0.06	-0.36	0.03	0.18	0.24	-0.07	0.00	.688**
help for problem with alcohol/drugs	0.20	0.15	0.13	0.21	0.12	0.31	0.11	0.28	-0.19	0.08
follow c/m advice	0.14	0.26	0.30	0.18	0.36	0.30	0.18	0.41	0.29	-0.19
how much cm help?	0.06	-0.12	0.19	0.25	0.26	0.27	0.17	0.34	.457*	0.10
# MH hospitalizations/6 months	-.462*	-0.14	0.08	0.44	-0.08	0.38	-0.23	0.13	0.10	-0.20
Quality of Life	0.04	-0.17	0.22	0.00	0.29	0.04	0.01	0.31	0.28	0.32

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Appendix B. Overall Themes from Peer Specialist Focus Group

1. Listening – Just sitting with someone makes a difference.
2. Build recovery of an individual's dreams and goals through support and education
3. Flexibility is key in this work to avoid burnout.
4. Doing with, not for
5. It helped my recovery
6. Peers need to take care of themselves

Themes with selected quotes

1. Listening – Just sitting with someone makes a difference.

"It was important to listen to their needs and make myself available to what they requested. It was not about how much time I spent but that I was there. One woman in particular was very busy and had 3 kids and no time to talk to me. She only calls when she has a need. One day she did call and I later found out that after we hung up she called the crisis center and was contemplating suicide and she went to the hospital. She could see the light at the end of the tunnel. "Talking to me made all of the difference in the world."

"One participant stated, 'I did not think anyone knew I was alive.'"

"One participant that I see is very paranoid and always calls at odd hours. She feels that she can trust me since we have built an understanding. She calls me in crisis due to connection of understanding what she is going through."

2. Build recovery of an individual's dreams and goals through support and education

"Helping people recognize their gifts. I share what connects me to them. Struggles in mental health can become gifts, they can be used for something good and that makes me happy. Broader issues I have become more aware of-Peer Stigma for example-mostly aware of how hard it is to work on recovery and relapse.

"It was the first visit with an isolated individual who hadn't left the apartment except going to a crisis center and was almost taken by police. She was upset very often; however, just talking to a Peer Specialist helped her to become involved in a WRAP Program. Over time she got in-home counseling, and was able to talk about what to do when she was stressed. We used index cards for reference for her. As time passed we met at a coffee shop and then I helped connect her to a local arts and crafts center so that she could be involved in getting out."

"Listening to needs is important. One person that I talked to wanted to go to Peer Specialist training as well."

3. Flexibility is key in this work to avoid burnout.

"It is the peer's (participant's) agenda not always what we want."

"Being available is very important. It's 'not causes we choose but what chooses us'. I get repeated calls. I remember what I was feeling when I was in their shoes… people want to deal with their problems in real time."

"When sitting with someone with issues (benefits…) often times we want to communicate as case managers but we are not case managers and we refer the participants back to case managers to deal with those things."

"A challenge for me would be losing contact with people for weeks at a time. Understanding and being persistent that these people are dealing with issues - legal issues, custody…. I have been able to reconnect with them. Being flexible and understanding that they will come back with persistence is important."

"I agree that persistence and not giving up on them. By calling them every week and leaving a message they will come back."

"Being able to let go if they don't come back this is difficult for me at times."

4. Doing with, not for

"That is a learning curve, wanting to make the calls for the participant but had to reign myself in because I am here to listen and support."

"When I listen to them I have to stop myself from giving advice. I have to let them guide themselves to get to their own conclusions. I am good at conquering that now. I say "No I am not gonna do that now" Just like that lady with knee pain didn't know what to do so I had to tell her what to do- ordinarily I would have made the call for her services. That obstacle is in me that I wrestle with."

"A big challenge for us is transportation. We cannot take people in our cars due to insurance. If people want something it's probably better that they can map it out and do it for themselves."

"People can become dependent on us. We want them to be able to maneuver on their own."

5. It helped my recovery

"Life Experiences… some I wish I could change or not go through, but being able to share what I have learned has been good. Even though I would not want to do it again I am glad that I can help people. It gave me a reason to be grateful for my life."

"When I talked with PeerLink people I can relate to them. A participant said she did not remember if she had taken meds… that was something that I had also done too and I had to write it down with dates and times. Even 15 minutes I cannot remember. She does that now too. It was a good idea to share with her."

"It helps my recovery. That's basically how it helps. It helps me to be aware of my symptoms, helps me to get support, and helps me to stay on track."

"WRAP Plan is wonderful. It is wonderful to be able to get this action plan so we can put it into people's hands. Every time we go over the section it reinforces how it has helped me in my life."

Self -Understanding, Self-Esteem, Self Worth. I am worth more than I thought of. It helps my family. It gave me a greater sense of purpose than before.

6. Peers need to take care of themselves

"I can only take so much… In order to help that feeling, for a couple of days I will have to do something I enjoy. This is so I can be available when I need to since I am also in recovery. I think that you can just get drained."

"I also get drained. I have to pace myself and create boundaries. People recover in their own way; you have to try not to take things that can be seen as a fall back, personally."

"I agree with the boundaries. I am always thinking about the clients on weekends and was able to use the skills learned, and trust that her recovery will go ok."

Additional Peer Suggestions for improving PeerLink:

"Most cold calls I made at the beginning of the study I lost. I would advocate for more introduction of program to the participants. A List describing more of program so people know more about it: who the person is, objectives, etc."

"Some people we called did not know why we were calling. More information provided would be helpful."

"I felt unannounced and that's where I lost people on first or second call. It was hard to relate the program to them by myself. There was a lack of understanding from them about the program."

“I developed a script and that was helpful for those calls.”

“Insurance tells people about the program. Some were more aware than others. Having DVD or booklet about PeerLink to hand out that is more detailed would be helpful. Some dropped out after 1st contact most often since they didn't know what it was about.”

Appendix C. Survey – Participant/Client

HIC#_____

[Cover Page]

1C. PeerLink – Participant/Client Survey

(please note that the survey instrument will cut and pasted from this document and re-formatted before printing final version)

Participant #					**			0	1

This number or code can be whatever you decide. It is up to you to remember. You will be asked to use the same code in 6 months for the second survey. You must use letters and numbers in your code. Please do not include your day of birth, social security number, or name.

The last 2 digits are filled in on the document to indicate location:
01=Wisconsin
02=Tennessee

Date _____

When you have completed the survey, Please be sure to put the survey in the envelope provided. Seal the envelope. Then give the envelope to the staff person administering the survey. Thank you!

Self-	Interview	Mixed

Administered		

We are interested in learning more about projects like this, so we're coming to the experts—the people who use these peer related services. We want to hear what you have to say about your experiences. There are no right or wrong answers to these questions; we're interested in *your* opinions.

If you have any questions while completing this, please feel free to ask at any time. Someone will be glad to help!

First, here are some background questions . . .

DEM1) How old are you? _____

DEM2) Do you consider yourself primarily White, Black, American Indian, Latino/Spanish, American Indian/Native American or Asian? Please check all the boxes that apply to you.

- ☐ White/Caucasian
- ☐ Black/African-American
- ☐ American Indian/Native American or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Spanish or Hispanic or Latino
- ☐ Other, please specify _____

DEM4) Are you male or female? Please check one: Male Female

DEM5) What is the highest grade of school you have completed? Please check one box.

- ☐ Less than High School
- ☐ High School or Equivalent (GED)
- ☐ Vocational or Technical training
- ☐ Some college
- ☐ Graduated College, if yes list degree (s)_____

DEM6) What is your marital status? Check the one box that best describes your marital status right now.

- ☐ Single (never married)
- ☐ In a relationship (not married)
- ☐ Married (or Domestic Partner)
- ☐ Separated

☐ Widowed

☐ Divorced

DEM7) What kind of place are you currently living in? Please check one box.

☐ Group home

☐ Adult foster care

☐ Rooming or boarding house

☐ Staying with parents/relatives (their place)

☐ Staying with friends (their place)

☐ My own house/apartment—alone

☐ My own house/apartment—with family and/or friends

☐ No current residence (living in a shelter or on the streets)

☐ Other (please specify) _____

GQL1) Which of the following best describes how you feel about your life as a whole? Please check one box.

☐----------☐----------☐----------☐----------☐----------☐----------☐

1 2 3 4 5 6 7

Terrible Unhappy Mostly Dissatisfied Mixed (about equally satisfied and dissatisfied) Mostly Satisfied Pleased Delighted

Next are questions about your involvement with your peer specialist…

CU1) **How long have you been linked to your peer specialists? Please check one box**.

☐ A few weeks ☐ 1 month ☐ 2 months ☐ 5 months ☐ six months (but less than a year)

CU2) **How often do interact with your peer supporter? Please check one box**.

☐ Every day of the week ☐ Several times a week ☐ About once a week

☐ A couple times per month

CU3) ***Would you say that the amount of time that you spend with your peer specialist is:***

☐ *Too much time* ☐ *Just the right amount of time* ☐ *Not enough time (wish I had more time)*

Some People have described various *reasons for working with a peer specialist*. For each item below, <u>circle the one</u> answer that best describes whether each of these is a reason for you			
RTC1) To learn about advocacy	**Yes**	*No*	**Sometimes**
RTC2) To socialize	**Yes**	*No*	**Sometimes**
RTC3) To get support from someone with similar experiences.	**Yes**	*No*	**Sometimes**
RTC4) To find out about other community resources	**Yes**	*No*	**Sometimes**
RTC5) To learn about discussion groups and other classes.	**Yes**	*No*	**Sometimes**
RTC6) Because I have nothing else to do	**Yes**	*No*	**Sometimes**
RTC7) To get help finding a job	**Yes**	*No*	**Sometimes**
RTC8) To talk to about problems or challenges	**Yes**	*No*	**Sometimes**
RTC9) Because I have to (meaning, someone made you get a peer specialist)	**Yes**	*No*	**Sometimes**
RTC10) To learn about recovery and mental health	**Yes**	*No*	**Sometimes**
RTC11) To work on my recovery plan	**Yes**	*No*	**Sometimes**
RTC12) To learn more about WRAP	**Yes**	*No*	**Sometimes**
RTC13) To attend support groups	**Yes**	*No*	**Sometimes**
RTC14) To get help to find some place to live	**Yes**	*No*	**Sometimes**
RTC15) I come here for some other reason: Please tell us what it is: _____	**Yes**	*No*	**Sometimes**

Reasons to Come Scale (RTC)

For each of the following questions, circle the **one** answer that is most true for you right now.

Strongly Agree	Agree	Disagree	Strongly Disagree
SA	A	D	SD

	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**
1. My living situation feels like a safe home to me.	**SA**	**A**	**D**	**SD**
2. I have people I trust whom I can turn to for help.	**SA**	**A**	**D**	**SD**
3. I have at least one close mutual (give-and-take) relationship.	**SA**	**A**	**D**	**SD**
4. I am involved in activities I find meaningful.	**SA**	**A**	**D**	**SD**
5. My psychiatric symptoms are under control.	**SA**	**A**	**D**	**SD**
6. I have enough income to meet my needs.	**SA**	**A**	**D**	**SD**
7. I am learning new things that are important to me.	**SA**	**A**	**D**	**SD**
8. I am in good physical health.	**SA**	**A**	**D**	**SD**
9. I have a positive spiritual life/connection to a higher power.	**SA**	**A**	**D**	**SD**
10. I like and respect myself.	**SA**	**A**	**D**	**SD**
11. I'm using my personal strengths, skills or talents.	**SA**	**A**	**D**	**SD**
12. I have goals I'm working to achieve.	**SA**	**A**	**D**	**SD**
13. I have reasons to get out of bed in the morning.	**SA**	**A**	**D**	**SD**
14. I have more good days than bad.	**SA**	**A**	**D**	**SD**
15. I have a decent quality of life.	**SA**	**A**	**D**	**SD**
16. I control the important decisions in my life.	**SA**	**A**	**D**	**SD**
17. I contribute to my community.	**SA**	**A**	**D**	**SD**
18. I am growing as a person.	**SA**	**A**	**D**	**SD**
19. I have a sense of belonging.	**SA**	**A**	**D**	**SD**

20. I feel alert and alive.	**SA**	**A**	**D**	**SD**
21. I feel hopeful about my future.	**SA**	**A**	**D**	**SD**
22. I am able to deal with stress.	**SA**	**A**	**D**	**SD**
23. I believe I can make positive changes in my life.	**SA**	**A**	**D**	**SD**
Check the box that is true for you now.	**YES**	**NO**		
24. I'm not working, but see myself working within 6 months.	**YES**	**NO**		
25. I am working part time (less than 35 hours a week).	**YES**	**NO**		
26. I am working full time (35 or more hours per week).	**YES**	**NO**		
27. I am not currently seeking employment.	**YES**	**NO**		
28. I am in school.	**YES**	**NO**		

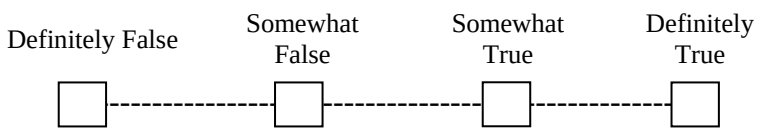
Recovery Markers Scale

How you think about yourself…

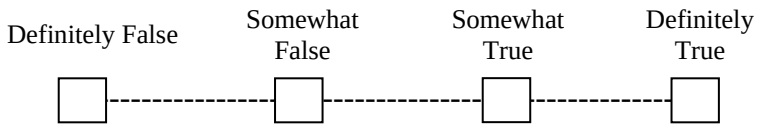
[State Hope Scale]

Using the choices shown below each statement, please **check the one box** that best describes *how you think about yourself right now*. Please take a few moments to focus on yourself and what is going on in your life at this moment. Once you've thought about yourself "here and now," go ahead and answer each item.

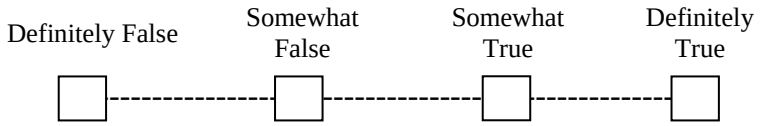
SH1) **If I should find myself in a jam, I could think of many ways to get out of it.**



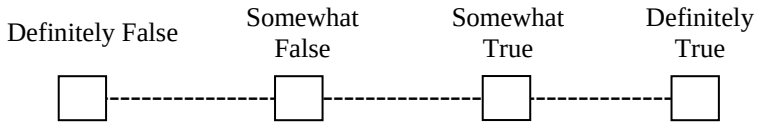
SH2) **At the present time, I am energetically pursuing my goals.**



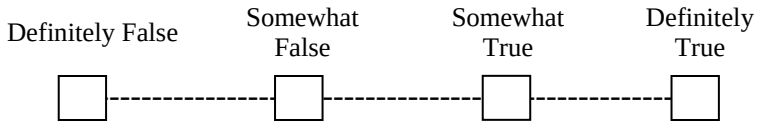
SH3) **There are lots of ways around any problem that I am facing now.**



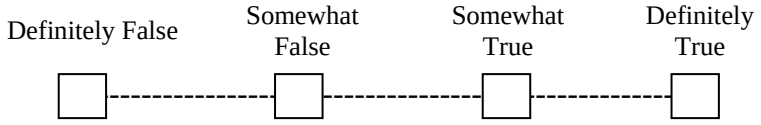
SH4) **Right now I see myself as being pretty successful.**



SH5) **I can think of many ways to reach my current goals.**



SH6) **At this time, I am meeting the goals that I have set for myself.**



Social Support Questionnaire

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
SA	A	N	D	SD

Using the scale above, please rate the extent to which you agree or disagree with the following statements:

1. There is a special person who is around when you are in need.

SA	A	N	D	SD

2. There is a special person with whom you can share joys and sorrows.

SA	A	N	D	SD

3. Your family really tries to help you.

SA	A	N	D	SD

4. You get the emotional help and support you need from your family.

SA	A	N	D	SD

5. You have a special person who is a real source of comfort to you.

SA	A	N	D	SD

6. Your friends really try to help you.

SA	A	N	D	SD

7. You can count on your friends when things go wrong.

SA	A	N	D	SD

8. You can really talk about your problems with your family.

SA	A	N	D	SD

9. You have friends with whom you can share your joys and sorrows.

SA	A	N	D	SD

10. There is a special person in your life that cares about your feelings.

SA	A	N	D	SD

11. Your family is willing to help you make decisions.

SA	A	N	D	SD

12. You can talk about your problems with your friends.

SA	A	N	D	SD

13. Your spouse/partner supports (or would support) your efforts not to smoke.

SA	A	N	D	SD

14. You have some family or friends who help you (or would help you) not to smoke.

SA	A	N	D	SD

MENTAL HEALTH CONFIDENCE SCALE

We would like to know how confident you are about your ability to help yourself deal with those things that commonly influence our lives. For each item, indicate how confident you are that you could do something to help yourself right now.

	Very Unconfident	Unconfident	Slightly Unconfident	Slightly Confident	Confident	Very Confident
1. Be Happy	1	2	3	4	5	6
2. Feel hopeful about the future	1	2	3	4	5	6
3. Set goals for yourself	1	2	3	4	5	6

4. Get support when you need it?	1	2	3	4	5	6
5. Boost your self esteem	1	2	3	4	5	6
6. Make friends	1	2	3	4	5	6
7. Stay out of the hospital	1	2	3	4	5	6
8. Face a bad day	1	2	3	4	5	6
9. Deal with losing someone close to you	1	2	3	4	5	6
10. Deal with feeling depressed	1	2	3	4	5	6
11. Deal with feeling lonely	1	2	3	4	5	6
12. Deal with nervous feelings	1	2	3	4	5	6
13. Deal with symptoms related to your mental illness diagnosis	1	2	3	4	5	6
14. Say no to a person abusing you	1	2	3	4	5	6
15. Use your right to accept or reject mental health treatment	1	2	3	4	5	6
16. Advocate for your needs	1	2	3	4	5	6

In this next section we have some questions about the mental health services you receive from *other* sources (not at this place and not with the peer specialist). Here are some questions about services related to your mental health in the last 30 days. Please circle YES or NO.

SU1) Have you gone anywhere for emergency psychiatric services in the last 30 days? Yes No

SU2) Have you been hospitalized for **mental health** problems in the last 30 days? Yes No

SU4) How many times in the last 30 days did you see your doctor about your mental health medications?

_____ times

SU4a) Do you have a case manager or therapist? Yes No

SU5) How many times in the last 30 days did you see your case manager or therapist? _____ times

SU7) Do you regularly go to meetings of AA, NA, or some similar group? Yes | No

SU8) Do you regularly go to self-help or support groups for mental health problems like Recovery, MDDA, Schizophrenics Anonymous, etc.? Yes | No

CF2) In the past 30 days, how much have you needed mental health services? **Please check one box**.

- ☐ Not at All
- ☐ A Little
- ☐ A Lot

And here are some questions about services for alcohol and drug abuse problems. Please check YES or NO…

SU10) Has anyone ever told you that you had a drug or alcohol problem? Yes | No

SU10a) Do you think that you have a problem with alcohol or drugs? Yes | No

SU11) Do you consider yourself in recovery from a problem with alcohol or drugs? Yes | No

SU12) During the past 3 months, did you get any help for any problem you had with alcohol or drugs? Yes | No

Many people go to a case manager or therapist for help with mental health problems. We want to know how much this helps you…

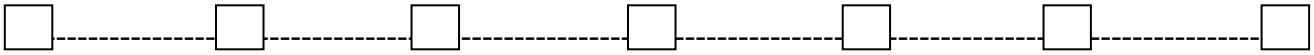
SS0) How much do you follow your case manager's or therapist's advice?	**Not at All**	**A Little**	**A Lot**
SS4) How much does your case manager or therapist help you overall?	**Not at All**	**A Little**	**A Lot**

Now we would like to ask you about any hospitalizations you may have had for mental health problems . . .

H1) How many times have you been hospitalized within the last 6 months for mental health problems? Please **check one box.**

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3 or more

GQL1) Which of the following best describes how you feel about your life as a whole? Please check one box.



1	2	3	4	5	6	7
Terrible	Unhappy	Mostly Dissatisfied	Mixed (about equally satisfied and dissatisfied)	Mostly Satisfied	Pleased	Delighted

CMTS1) We would love for you to write anything else you want to tell us about what the PeerLink project in the space below or on the back of the page**:**

Thanks for sharing your valuable thoughts and opinions! Your participation in this evaluation will help others to create and improve programs like this one.

Place the Survey in the envelope provided, seal it, and place either in the box or give the sealed envelope to the PeerLink Supervisor.