Los Angeles County
MHSA Innovation Program

Annual Report of Peer Models (PRISM and PRRCH)
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LAC DMH Los Angeles County Department of Mental Health — Hope, Wellness, Recovery

Health Services Research Center — University of California, San Diego

harder+company community research

USC Social Work

“To Enrich Lives through Effective and Caring Service”

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Executive Summary

Peer-run organizations are consumer-operated services or self-help organizations that are staffed and operated by individuals with lived experience with the mission of using peer support, recovery and illness education, and advocacy to promote wellness, empowerment, and recovery for individuals (Campbell et al., 2006). While the concept of peer-run services has been around since the 1970s, it is only within the last decades that trained peer support specialists and peer-run organizations have become a more integrated part of our public mental health service system (Ostrow, 2014). However, only recently has there been interest in the characteristics and structure of peer-run organizations nationally. Peer-run organizations vary in their design, and while still small in number, provide essential services to individuals and continue to develop. Peer-run crisis respites (PRCR) are an emerging form of residential environment that offers a person-centered alternative to usual care and aim to prevent crises and reduce psychiatric hospitalizations. Respites are completely staffed and operated by individuals with lived experience of mental health challenges (i.e., peers). The sharing of success stories of acute residential alternatives and evidence-based practices has contributed to the rapid expansion of peer respites across the country, outpacing current research. Only recently have PRCR programs in their current form come into existence, and we need to better understand how they operate, their effectiveness, and disseminate information about them. For these reasons, it is important to document and evaluate peer-run programs.

The following report is the result of the Los Angeles County Department of Mental Health (LACDMH) Innovation (INN) Program evaluation of the Peer-Run Model, which was designed to utilize peer staff as social support to help individuals receive the holistic services they need to improve their overall health and wellbeing. The Peer-Run Model includes the Peer-Run Respite Care Homes (PRRCH) and the Peer-Run Integrated Service Model (PRISM). PRRCH provides a safe and healing short-term residential environment for individuals with mental health concerns who may also have health and substance abuse concerns. PRISM is an alternative to formal public mental health services that offers opportunities for social connections and connections to the community, as well as referrals and skills training to support and empower people to take responsibility for their own recovery. Both types of peer-run programs were designed and are run by individuals with lived experience. This report will briefly describe the evaluation methods used and highlight the positive impact of these programs, as well as document the challenges and lessons learned in order to develop best practices for peer-run organizations locally and nationwide.

Data Highlights

- Individuals at both PRISM programs experienced a reduction in number of days spent homeless six and twelve months after joining PRISM.
- Six months after joining PRISM, more than twenty five percent of participants at both programs reduced the number of emergency room visits compared to baseline.
- PRISM participants experienced significant improvements in several items on the Illness Management and Recovery scale, including time in structured roles and knowledge about symptoms, treatment, coping strategies (coping methods) six and twelve months after joining the PRISM program.
- Across both models, while each program facilitated different types of linkages and referrals to assist and support individuals achieve their goals, the majority of linkages were successful and utilized by individuals.
- Satisfaction with the PRISM and PRRCH programs was high. The majority of participants and guests agreed that there are people available to talk with as often as they felt was necessary, and felt that their mental health, physical health and substance use concerns were addressed by the programs.
- PRRCH staff interviewed during the Provider Focus Group and guests who participated in the Respite Study emphasized that PRRCH had a positive impact on guests' relationships and social support by helping build people's life skills and interpersonal skills.

- PRRCH guests interviewed also reported that their respite stay provided support and space so they could begin to treat or manage physical and mental health issues.

Based on data from this evaluation, these peer-run programs help support people with their recovery from mental health, physical health, and substance use concerns. The current findings are promising and illustrate the need to continue peer-run programs to continue learning about their effectiveness and best practices. The peer-run programs and this evaluation also document important lessons learned that can be applied to the field of peer services and systems of care overall.

Learning

Peer model supervisors at LACDMH stressed that it was important that the programs were focused on learning, with providers and LACDMH all learning from and with each other. Peer model supervisors supported this learning environment by reiterating the learning focus at monthly peer provider roundtable discussions, providing regular training opportunities, and encouraging the use of evaluation data and observational data to conduct continuous program improvement. During the Provider Focus Groups, PRRCH and PRISM staff shared examples of implementation challenges, how they were overcome, and suggestions for how to most effectively continue the programs. While many of these challenges were the same for both providers and models, such as hiring and training qualified peer staff and outreach and engagement, providers utilized different methods to overcome these challenges, including developing partnerships with recovery organizations and becoming co-located at a community organization.

The current evaluation was intended to provide the same rigor as the evaluation of the other Innovation models of care. This method of evaluation is rare for peer-run programs, which often face institutional barriers to evaluation. Although peer staff initially shared concerns about using measures not developed specifically for peer program, the programs supported the need to evaluate the effectiveness of their programs.

With the increasing interest in peer-run programs within California and nationwide, there is a greater need to overcome these inherent challenges of evaluating these programs in order to develop best practices and expand funding opportunities. Despite some limitations and challenges to the current evaluation, it has demonstrated several promising techniques, including training methods and collaboration with peer staff, to increase buy-in of evaluation activities, and improve the reliability of evaluation outcomes. These techniques can help future evaluations to better demonstrate the efficacy and strengths of peer-run programs, enabling funders and decision-makers to better justify funding for peer-run programs and integrate them into the overall systems of care. Peer model supervisors at LACDMH see the current evaluation approach of collecting data and analyzing outcomes as an advancement that could be applied to the rest of the peer system.

MHSA Innovation Evaluation

With funding from the California Mental Health Services Act (MHSA), the Los Angeles County Department of Mental Health (LACDMH) Innovation (INN) program began in 2012 and focused on identifying new and promising practices to integrate mental health, physical health, and substance use/abuse services for uninsured, homeless, and underrepresented populations. To achieve this purpose, LACDMH, in collaboration with its community stakeholders, designed four models of care to serve different underrepresented populations, and to promote community collaboration and service integration for consumers and their families.

The implementation of INN was supported by a robust evaluation to assess the implementation process and the impact of services. The evaluation was conducted by University of California, San Diego, Harder+Company Community Research, and the University of Southern California.

The INN program models of care include the Integrated Clinic Model (ICM), the Integrated Mobile Health Team Model (IMHT), the Community-Designed Integrated Service Management Model (ISM), and the Integrated Peer-Run Model. Evaluation findings for three of the four models are published in two Annual Reports (see LACDMH Innovation web page here). The Peer-Run Model was implemented on a different timeline with its programs beginning one year after the other models in 2013 and continuing through June 2016. The current report describes outcomes and learning from the Peer-Run Model.

Peer-Run Model

Unlike the other three INN models of care, the Peer-Run Model does not directly provide integrated healthcare. Peer staff provide social support to help individuals receive the holistic care they need to improve their overall health and wellbeing. Despite these differences, all INN four models share the vision of improving the quality of care for individuals by providing an integrated physical health, mental health, and substance abuse treatment program for specific vulnerable populations in a large, diverse urban environment and in a complex system of care.

The Peer-Run Model uses two distinct strategies for peer support to achieve this vision. The Peer-Run Model includes the Peer-Run Respite Care Homes (PRRCH) and the Peer-Run Integrated Service Model (PRISM). PRRCH provides a safe and healing short-term residential environment for individuals with mental health concerns who may also have health and substance abuse concerns. PRISM is an alternative to formal public mental health services that offers opportunities for social connections and connections to the community, as well as referrals and skills training to support and empower people to take responsibility for their own recovery. Both types of peer-run programs were designed and are run by people with lived experience.

Peer model supervisors at LACDMH shared that "the original intention [of the model] was to develop a very specific role for peers as it related to integrated care." In addition, the PRRCH program was intended as a cost-effective alternative to hospitalization for individuals experiencing a mental health crisis. However, changes in leadership within the Department resulted in a revision to the model's focus and Scope of Work. Specifically, LACDMH staff highlighted that the model shifted away from acting as a crisis intervention. Instead the model's purpose was to focus on learning about the specific roles for peers in the overall system of care. These changes to the scope delayed the implementation of the model by one year.

Peer-Run Respite Care Homes (PRRCH)

Mental health systems across the United States struggle to deliver patient-centered care to individuals with serious mental illness who experience psychiatric crises. Forced medication, seclusion, restraint, and extended emergency department wait times, all of which can be traumatizing and counter-therapeutic, have been well documented,[1] as has the shortage of outpatient mental health providers, which may contribute to reliance on emergency services.[2] Across the country, peer respites function as psychiatric hospital diversion programs by

[1] Madan A, Borckardt JJ, Grubaugh AL, et al. Efforts to reduce seclusion and restraint use in a state psychiatric hospital: a ten-year perspective. *Psychiatr Serv*. 2014;65(10):1273-1276.

[2] Hyde PS. *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*. Washington, DC: U.S. Department of Health and Human Services: 2013.

offering a patient-centered alternative to usual care and aiming to prevent crises.[3] The dissemination of acute residential alternatives and peer support evidence-base has contributed to the rapid expansion of peer respites across the country,[3] outpacing current research. No published studies have examined the comparative effectiveness of various peer respite designs.[4]

Informed by respites across the country yet not focused on psychiatric crises, LACDMH's PRRCH programs were designed to support people who are not a danger to others, who have a chronic mental health, physical health, and/or substance use concerns, and can perform basic daily living skills independently. PRRCH is intended to provide a safe and healing temporary living environment where people can learn coping and life skills to help them improve their overall wellness in a relatively brief time (up to 30 days). Guests are empowered to seek out resources and support services that they can utilize after leaving PRRCH.

Peer-Run Integrated Services (PRISM) Model

Developed in collaboration between the LACDMH INN program supervisors and Peer-Run Model providers, PRISM is dedicated to supporting recovery and wellness through a focus on personal empowerment, and the development of life skills and social support networks. PRISM is based on a "whatever it takes" philosophy in a context of personal choice. PRISM was designed, and is operated by peers to be a member-driven, holistic approach to wellness. Participants often have mental health challenges with co-occurring physical health concerns and/or substance use. PRISM encourages participants to find resources that will assist in their recovery, including: self-help support groups, educational or enrichment classes, primary care doctors, mental health clinicians, housing support, and substance abuse services.

[3] Ostrow L, Croft B. Peer respites: a research and practice agenda [published online ahead of print March 1, 2015]. *Psychiatr Serv*. doi:10.1176/appi.ps.201400422.

[4] Madan A, Borckardt JJ, Grubaugh AL, et al. Efforts to reduce seclusion and restraint use in a state psychiatric hospital: a ten-year perspective. *Psychiatr Serv*. 2014;65(10):1273-1276.

Peer-Run Model Providers

The PRRCH and PRISM models were implemented by two community providers: Project Return Peer Support Network (Project Return) and Self-Help And Recovery Exchange (SHARE!). Each provider designed and implemented a PRRCH and a PRISM program. A brief description of each agency is provided below. More detailed information about their programs is included in subsequent sections of this report.[5]

Project Return Peer Support Network promotes wellness, personal growth, and self-determination for people who have experienced mental health challenges by providing social opportunities, education, and community involvement. Project Return demonstrates that self-help is a valuable part of recovery. Programs illustrate the benefits of building a base of support among peers–to share goals, conquer fears, and celebrate successes. Project Return believes that people should be recognized by their skills and be encouraged to develop their abilities. This belief is reflected in its programs which include: *more than 100 Self-Help Groups* in Los Angeles County; a bilingual, after-hours *Warm Line* staffed by peers providing support to people with mental health challenges; *Peer Advocate Training* that helps peers gain employment in Peer Support Specialist roles throughout Los Angeles County; *El Centrito de Apoyo* and *Un Paso Mas,* Spanish-language community outreach centers; a *Community Outreach Program,* which provides outreach to people in residential facilities; and the *Activity Captain Program,* that helps peers plan and execute social outings to promote skill development and independence. More information can be found at the organization's website: http://www.prpsn.org.

SHARE!'s mission is to help people in Los Angeles pursue personal growth and change. SHARE! empowers people to change their own lives and provides them a loving, safe, non-judgmental place where they can find community, information, and support. SHARE! was originally founded in 1992 as a safe place for incest survivors to recover. Fundamental to the organization is that no one is refused services or support–all are welcome. SHARE! has two sites: Downtown Los Angeles and Culver City. SHARE! only hires people with lived

[5] Provider descriptions are informed by the evaluation team's review of the providers' websites and the initial site visit in 2013.

experience and gives them further training on peer support, self-help groups and community resources. SHARE!'s programs and services include: *Self-Help Support Groups,* which include an array of specific support groups that are led by the participants with no outside facilitator; *Volunteer-to-Job Program* that helps people learn job skills and then places them in jobs; assistance in obtaining *Permanent Supportive Housing*. Additional information about SHARE! can be found at http://www.shareselfhelp.org.

Report Aims

This is the first full evaluation report for the Peer-Run Model. Due to the unique nature of each program and each provider, a narrative approach was adopted to tell the story of how each peer-run program was implemented, its impact on participants and providers, as well as learnings and reflections from the perspectives of the providers, LACDMH peer model supervisors, and the evaluation data. In addition to describing the peer-run programs, this report is also intended to identify elements of the Peer-Run Model that could more broadly be incorporated into the mental health system. These could include areas where peer-run programs can collaborate with other DMH or traditional healthcare providers, and unique roles that peers can play within the existing system of care. This report is not intended to be used to compare the relative success of the two providers as their organizational structure, program activities, and participants' characteristics and needs differed.

How to read this report

This report is organized in three main sections: (1) description of the PRRCH programs, (2) description of the PRISM programs, and (3) discussion/lessons learned. Each program section presents findings from each community provider and a summary of key lessons learned by providers for each model. Additional information on INN can be found in Appendix A, and additional information on the evaluation methodology can be found in Appendix B. A summary of Project Return and SHARE! data highlights can be found in Appendix C.

To be culturally appropriate with the peer-run philosophy, people who participate in the Peer-Run Model are referred to as guests or participants.

Evaluation Methodology

As part of the overall LACDMH INN evaluation, the evaluation team implemented the Peer-Run Model evaluation in close collaboration with LACDMH and the peer providers. Evaluation activities began in February 2013 simultaneously with the beginning of the peer-run programs. The evaluation team, in consultation with LACDMH, implemented a variety of qualitative and quantitative evaluation techniques to best address the needs of LACDMH and the peer programs. Outcomes data included in this report was collected from implementation of the model through October 1, 2015.

Quantitative techniques used measurable outcomes from the Innovation Health Outcomes Management System (iHOMS) assessments to uncover patterns in participant characteristics, as well as changes in mental health, physical health and substance use/abuse. Qualitative approaches were used to examine the process of delivering peer programs and to support quantitative findings.

The evaluation methodology was tailored to the PRRCH and PRISM programs. While PRISM programs were intended to be similar in duration to the other INN programs, with most people participating in the program for over a year, the PRRCH program was time-limited to a maximum of 30 days. As a result, there was a limited opportunity to measure the direct impact of the PRRCH model using the longitudinal quantitative data that was collected by PRISM programs and the other INN programs. The PRRCH evaluation had more emphasis on qualitative data methods to describe short and longer-term impact to better ensure that the findings can be generalized to other respite settings.

Quantitative Evaluation

Peer support generally does not include "clinical assessment" and instead is intended to be non-judgmental and supportive. Peer staff initially shared concerns about using measures not developed specifically for peer program. They also shared concerns about asking peers to assess the recovery status of participants and guests because it is seen as conflicting with the mission of non-judgmental support. However, the programs supported the need for evaluation activities to demonstrate the benefits to participants and continue to improve their programs for participants.

For PRISM programs, the key indicators of overall health include physical health status improvement, mental health status improvement, substance use/abuse reduction, participant satisfaction, stigma and staff linkages based on the participant's goals. Although the peer model is fundamentally different from the other INN models, the same core quantitative measures were used across each model. This ensured that the evaluation could compare outcomes of the peer-run programs to the other INN programs as well as to national norms.

Assessments for PRRCH guests contained fewer measures, as participation was restricted to only one stay of 30 days or less, or long enough to complete one round of assessments. Quantitative measures included both guest- and staff- completed measures, and can be found in the table on page 5.

Data Analysis

For PRISM outcomes, the evaluation incorporated statistical analysis as well as additional analytical techniques to determine applied meaningfulness, or whether the changes on the outcome measures reflect meaningful changes in individual health. Together, these techniques ensure a more robust evaluation. Paired samples t-tests and chi-square tests were used to examine the statistical significance of changes in scores on the measures over time. Statistical analysis using paired or matched samples only include participants that have complete data for each time point being measured. Due to the small sample sizes of matched assessments, a p-value of ($p < .10$) was used to determine statistical significance of changes.

Applied meaningfulness is determined using the Minimal Important Difference (MID), which represents the smallest improvement in a scale score that would indicate an observable change in participant health. If the difference between a participant's baseline and follow-up scores on a specific outcome measure is greater than the MID, that guest is considered to have achieved an applied meaningful change for that outcome. Additionally, for some measures, maintaining an optimal score was important when considering participant recovery over time (for example, no alcohol use). For these measures, the percentage of participants who maintained optimal scores was included with the percentage of participants who had an applied meaningful improvement.

Analysis of cost-effectiveness will be also conducted and the findings will be included in a separate report in early 2016.

For additional information about the evaluation measures or data analysis, please see Appendix B.

Qualitative Evaluation

Due to the unique nature of the Peer-Run Model, the evaluation incorporated qualitative components to better describe the structure of the programs and the experience of participants. The evaluation team conducted in-person site visits with each PRISM and PRRCH provider in the spring of 2013. The site visit included a one- to two-hour conversation with program staff. During these initial site visits, the evaluation team learned more about the providers' work overall and their implementation plans for both the PRRCH and PRISM programs. The site visits informed the provider descriptions included earlier in the report and enabled the evaluation team to have an initial understanding of the programs.

Focus Groups: To directly inform this report, the evaluation team conducted Provider Focus Groups. These included four in-person focus groups with PRISM and PRRCH staff from each provider in the summer of 2015. For example, one focus group was with SHARE!'s PRISM staff and one was with their PRRCH staff. Each Provider Focus Group included at least three staff members. Additionally, a LACDMH Focus Group was conducted by phone with two peer model supervisors who have been involved in the Peer-Run Model since inception to capture their reflections about the model overall.

Respite Study: To explore short and longer-term outcomes for PRRCH guests, interviews with respite guests were conducted to learn why guests came to the respite, document their experience at the respites, and understand the respite's impact on them. Participation in these interviews was voluntary.

The study was designed in close partnership with the peer providers to help answer their learning questions. The peer providers vetted the study design and made specific suggestions central to the study. For example, the peer providers highlighted the need for interviews to be conducted by people with lived experience so that the peer-run respite environment was not impacted by non-peers interacting with guests during their stay.

Therefore, all interviews were conducted by trained peer interviewers. Peer interviewers had previous experience working as peers and also participated in in-depth initial training and on-going booster training to support their interviewer role throughout the study. Initial interviews were conducted toward the end of the guests' stay (N=45). Follow-up interviews were conducted with the same people three to six months after their stay was complete (N=26). The interviews were recorded and transcribed. Content analysis was conducted to identify central themes across interviews. Please see Appendix B for more information about the study.

This report only includes highlights from the respite study. A separate learning brief will be issued in early 2016 with additional findings and a more in-depth analysis of qualitative data.

PRISM and PRRCH Measures

PRISM Participant Measure	Description
PROMIS Global Health	Provides a broad rating of mental health, physical health, and social well-being.
Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS)	Measures specific mental health symptoms - compulsive behavior, psychosis, memory disturbance and depression - and positive recovery factors, which can help identify one's strengths.
PROMIS-Derived Substance Use	Assesses the negative consequences of substance use for participants who reported using alcohol or off-label prescription or illegal drugs on the Physical Health and Behaviors Survey.
Physical Health and Behaviors Survey	Allows participants to report on health behaviors, substance use, incarcerations, service use, medical history, and potential barriers to service. Additionally, participants reported their height, weight and blood pressure.
Internalized Stigma of Mental Illness (ISMI)	Assesses subjective experience with mental illness stigma including: Alienation, Perceived Discrimination, Social Withdrawal, Stereotype Endorsement and Stigma Resistance.
Feedback Survey	Assesses overall participant satisfaction with the program (beginning at the six-month assessment).

PRRCH Guest Measure	Description
Physical Health and Behaviors Survey	Guests reported their height, weight and blood pressure.
Feedback Survey	Assesses overall guest satisfaction during stay at respite home.

Staff Measure*	Description
Milestones of Recovery Scale (MORS)	Assesses participants' current level of recovery considering three factors: their level of risk, their level of engagement within the mental health system, and their level of skills and supports.
Illness, Management and Recovery Scale (IMR)	The IMR has 15 items, each addressing a different aspect of illness management and recovery.
Linkage Tracker	Tracks participants' goals and staff referrals to resources or support to help participants accomplish their goals, and the success of linkages.

*These are the same for PRISM and PRRCH.

All PRISM participant measures are completed every six months, except for the PROMIS Global Health, which is completed every three months. The MORS, IMR and Linkage Tracker are completed every three months. PRRCH guest and staff measures were completed towards the end of a guest's stay in the respite. Additional information on specific measures can be found in the Glossary.

Peer-Run Respite Care Homes (PRRCH)

Project Return Peer Support Network (Project Return)

PROGRAM DESCRIPTION BASED ON PROVIDER PERSPECTIVES

Project Return's PRRCH program–Hacienda of Hope–is a short-term living space that provides peer support to people with mental health or substance abuse concerns. It is located in Long Beach in the Century Villages at Cabrillo. Hacienda of Hope is run entirely by people with lived experience who provide support, mentoring, and coaching. Staff see the respite as a place to build skills to help avoid future hospitalizations. The respite environment was designed to help guests build relationships with the staff and each other. In the Provider Focus Group, staff noted that they become the guests' support and family upon entry to the respite because many of the guests have little social support. To help guests build their own social network, staff are careful to help guests establish relationships with other guests within the respite. As one staff person highlighted, *"…the whole point is that they don't become dependent on us but they build relationships and networks with others."* Staff encourage guests to engage and communicate with other house guests for peer support during dinner and breakfast meals, movie days, and daily interactions. Hacienda of Hope attempts to build a community for their guests by hosting events where people at the respite and respite alumni can socialize, and staff typically maintain contact after the person leaves the respite. As a result of these many interactions, the guests improve their socials skills.

According to staff, guests typically stay from three days up to 29 days with most people staying the full 29 days. Over time, staff saw the important benefit of guests having a longer stay at the respite. Program staff believe that "*thirty days is just enough time to say, 'I want to change my life' with the tools they have and the support to take that next step."* Each guest has his or her own room and shares a bathroom with one other guest. There are nine beds at Hacienda of Hope but only eight guests are allowed to stay at one time. The program is typically at full capacity. Breakfast is cooked by Project Return staff and guests, and guests have breakfast together. Guests then have the flexibility to work on their own goals (e.g., look for housing or a job), to attend a support group, or other commitments (e.g., court). Dinner is also provided for guests at a cafeteria affiliated with the Villages of Cabrillo. Every Friday, all guests gather together for a group meeting, which begins with everyone sharing something positive from their week. The meeting is intended to build community and encourage guests to support each other. It is also when staff review house rules and skills related to the living environment are taught (e.g., doing laundry). As one staff person shared, *"People have to work towards self-sufficiency like washing dishes after cooking. We start modeling and from there just coaching."*

Outreach and Engagement: Project Return has an outreach team that goes into the community to build relationships and raise awareness about the respite. The program gets referrals from other healthcare agencies such as Mental Health America – Los Angeles, United States Veterans Initiative, and Recovery Opportunities and Developing Skills (ROADS). People also hear about the respite through word of mouth from people who have stayed there or know about it. Some guests (6.5%) were referred to Hacienda of Hope from Project Return's PRISM program. When the respite first opened, people primarily connected to the respite through referrals. Now more people hear about it through word of mouth.

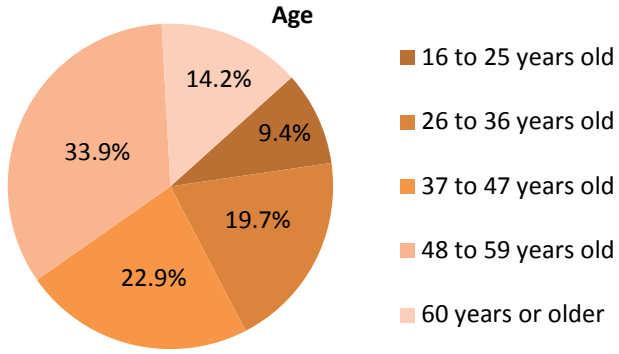
GUEST CHARACTERTISTICS

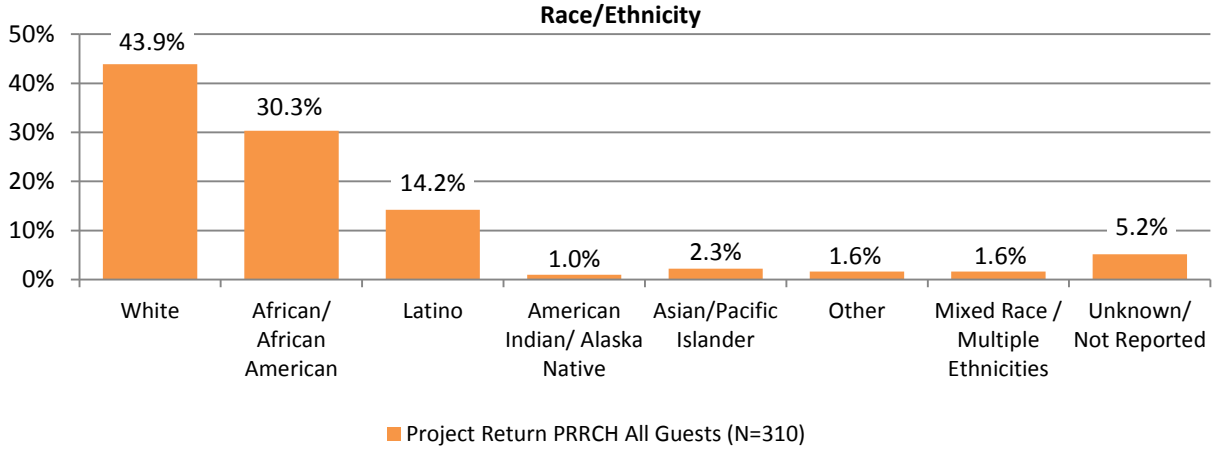
Hacienda of Hope is intended for adults who have mental health challenges. While the respite was not initially intended to serve people who are homeless, the respite expanded their enrollment criteria to include homeless individuals as a result of community need. Most of the guests wanted a different living situation because they had housing issues, such as living in a place that hindered their recovery. Staff described most guests as people who are suffering from some kind of psychiatric episode, who lack family support, adequate housing, and benefits (including medical and any other eligible benefits, such as SSI/SSDI). Many also do not have a high school diploma or GED.

People interviewed for the Respite Study reported that they came to the respite for housing or housing assistance, to have time away from their current living situation, or to receive support from other people. To date, 310 guests have stayed at Hacienda of Hope. More than five percent (5.5%) of guests had multiple stays at Hacienda of Hope–the most common reason for returning to the program is conflict with housemates or landlord.

Most guests who stayed at Hacienda of Hope were adults between the ages of 48 and 59 (33.9%).

Most guests identified as White (43.9%), followed by African/African American (30.3%).





Illness Management and Recovery (IMR): Staff Assessment of Mental Health

Staff are asked to complete the IMR Scale for each guest to assess recovery from the perspective of the peer staff member. The IMR can help staff identify specific areas that they feel may be challenges to the guest, as well as highlight other domains that may be potential strengths that can support recovery. It also provides a way to understand where guests are in their recovery process, on average, when they came to the respite. The IMR has 15 individual items, which, when averaged, make up an Overall score and three subscales: Recovery, Management, and Substance Use. IMR scores range from one to five, and lower scores indicate a guest is doing well in a particular domain or subscale.

Project Return PRRCH IMR Subscale Scores	
Recovery Subscale ***(mean of items 1, 2, 4, 8, & 12)***	**2.81 (N=266)**
Management Subscale ***(mean of items 6, 7, 9, & 11)***	**3.31 (N=266)**
Substance Use Subscale ***(maximum of items 14 & 15)***	**1.69 (N=257)**
Overall IMR Score ***(mean of items 1-15)***	**2.76 (N=266)**

Mental Health Status

The table to the left shows mean (average) Overall IMR scores, and Recovery, Management and Substance Use Subscale scores. Peer staff reported that alcohol and/or drug use was not a factor for 70.4% of guests. The average scores indicate that guests were less impacted by alcohol/drug use or further along in their substance use recovery when they enrolled in the program than with self-management and coping with their mental health and/or wellness.

Guest Reported Mental Health

Peer staff wanted to assess guests' feelings of self-efficacy. Together, the evaluation team and peer staff developed two items to assess this domain. Guests were asked about their self-esteem and sense of control on the Feedback Survey. Half of Project Return guests (50.8%) reported having a fairly high level (ratings between 6 and 10, on a scale of zero to 10) of self-esteem and 25.1% reported an average level of self-esteem during their stay. Most guests reported feeling either some control (25.9%) or a high level of control (ratings between 7 and 10, on a scale of zero to 10) over their life during their stay (47.1%).

Please rate your current level of self-esteem using the scale below. (N=171 Guests)										
Very low	1	2	3	4	Average	6	7	8	9	High
1.8%	0.6%	0.6%	11.1%	9.9%	25.1%	12.3%	8.8%	14.0%	5.8%	9.9%

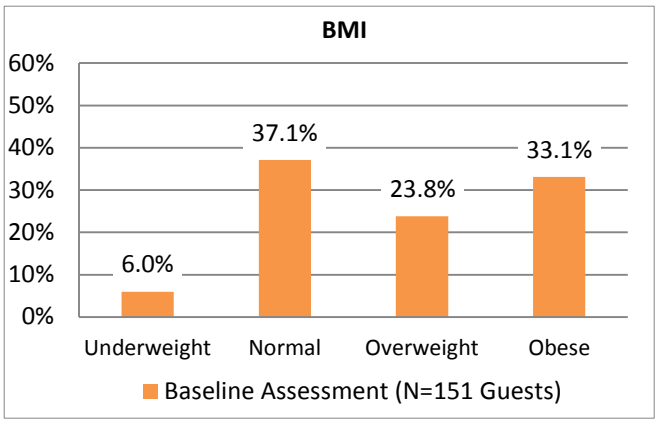
Please rate how much control you have over your life using the scale below. (N=170 Guests)										
No control	1	2	3	4	Some control	6	7	8	9	Complete control
1.2%	2.9%	2.4%	5.3%	6.5%	25.9%	8.8%	16.5%	14.7%	4.7%	11.2%

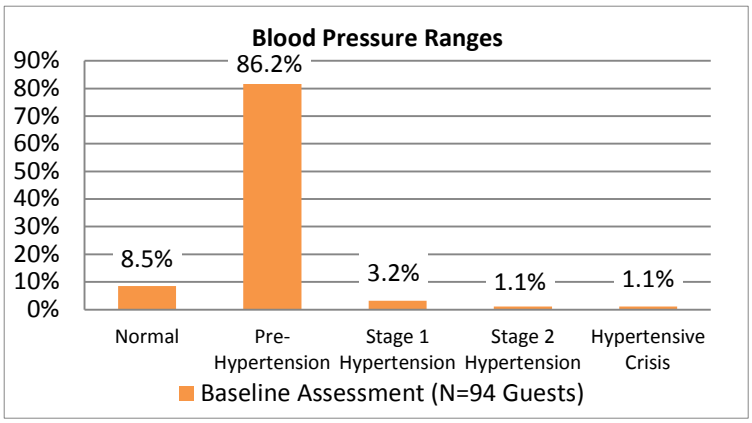
Guest Reported Physical Health Indicators

To get a basic picture of each guest's physical health, guests are encouraged to record their height and weight, and measure their systolic and diastolic blood pressure using blood pressure cuffs available at the respite. Guests' height and weight are used to calculate their Body Mass Index (BMI), a common method of determining whether an individual is at a healthy weight. Categories for BMI were determined using the standards published by the Centers for Disease Control (CDC). Systolic and diastolic readings were combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. These blood pressure categories, used in the table below, only reflect guests' risk for hypertension; additional criteria must be met for a diagnosis of hypertension.

Health Status

In general, most Project Return PRRCH guests had BMIs that were normal (37.1%) or obese (33.1%). The majority of guests at Project Return had pre-hypertension blood pressure (86.2%). Improving nutrition and/or increasing physical activity was one of the most common goals identified by guests and captured on the Linkage Tracker. As a result, Project Return implemented a weekly walking group in early 2015 to help guests improve their moods and these physical health indicators. Staff shared that guests who participated in the walking group started changing their eating habits as a result of the daily walking and it improved their physical health. The group has also been beneficial to improving guests' moods, and provides an important opportunity for guests to develop social skills. As guests walked, they communicated their problems and worked through them with others' support. The walking group is also an opportunity for guests to meet and bond with each other to establish friendships.





GOALS AND ACTION PLANNING

Early in their stay, guests create action plans with specific steps and tasks they want to accomplish while at the respite and beyond. For example, goals could include managing their emotions, finding better housing, losing weight, obtaining social security benefits, or finding a job. While guests have one main staff contact person, the entire team works closely with them to help support and coach guests toward achieving their individual goals. The staff use a simple chart to share example goals and steps to help overcome initial fear and encourage guests to identify their own goals. As one staff person shared, *"Sometimes they don't know [what goals to set]. They are afraid to have goals or their goals feel unattainable…"* Staff also help guests develop life skills, such as learning how to use public transportation or writing a resume. After setting goals, guests typically pursue them on their own, although staff are available to accompany them into the community to provide emotional or practical support.

Staff Reported Linkages and Referrals

The Linkage Tracker was developed for the peer programs to document guests' goals, linkages, and/or assistance support to achieve their goals, and the success of each linkage as reported by peer staff. The form was designed to align with the Eight Dimensions of Wellness identified by Substance Abuse Mental Health Services Administration's (SAMHSA). It includes the emotional, physical, environmental, social, occupational, financial, intellectual, and spiritual aspects of a person's life. These Dimensions of Wellness may help people better manage their concerns and experience recovery.

The most common goals expressed by guests and reported on the Linkage Tracker by peer staff were housing related (34.7%). Most described seeking more appropriate living arrangements or transitional housing so they were no longer homeless. Additionally, many guests described their goal to find housing in which they felt safer or that was more peaceful. Guests also described goals to improve their mental health and emotional wellness (19.1%), including symptom management, coping skills, and anger. Many guests were seeking increased social support, which included forming new friendships and finding/attending support groups, and also had goals to improve their relationships (24.8%).

Unlike case managers, who generally provide clients with specific referrals or resources, peer staff empower guests to work toward the goals that they establish for themselves and connect them with resources to help support their work toward their goals.

On average, the majority of guests (57.2%) had goals in only one dimension (out of a possible eight) that they wanted to achieve during their stay; the remaining 42.8 percent had goals in two or more dimensions. Guests were most likely to have a goal in the Environmental (49.8%) and/or Emotional (46.3%) Dimensions of Wellness. The table below shows the most common linkages peer staff and guests discussed within each Dimension of Wellness, as well as how often staff facilitated each linkage. While this table describes the most commonly made linkages, it is not an inclusive list of all the linkages that staff may have discussed with guests. Staff may have discussed more than one linkage with

a guest. It is important to note that (1) guests may have recovery or life goals in several different Dimensions of Wellness and (2) some guests may not have discussed any goals with staff upon first visiting a program.

Project Return PRRCH Linkage Tracker	
Most common linkages discussed with guests based on their goals (N=257 guests)	**How often was linkage made (% guests)**
Physical (18.3% of guests)	
Linked individual to exercise classes or groups	44.7%
Linked individual to nutrition classes or support groups	40.4%
Environmental (49.8% of guests)	
Linked or provided individual education or support maintaining independent living	40.6%
Linked individual with transitional living program	38.3%
Emotional (46.3% of guests)	
Linked individual to emotional wellness self-help group	73.9%
Linked or provided individual education or support on emotional wellness	68.1%
Social (17.1% of guests)	
Linked individual to social skills self-help group (eg. Conflict resolution, communication)	61.4%
Linked or provided individual education or support around social skills	59.1%
Linked individual to community events or activities based on their interests	59.1%
Occupational (11.3% of guests)	
Linked to or provided individual assistance in searching/applying for jobs	69.0%
Linked individual to assistance editing or creating a resume or cover letter	55.2%
Financial (10.5% of guests)	
Linked to or provided assistance to individual in establishing benefits	63.0%
Linked to or provided individual counseling on money management class or group	63.0%
Intellectual (4.7% of guests)	
Linked to or provided individual support with enrolling in educational classes	41.7%
Linked to or provided individual support to explore creative outlet or hobbies	41.7%
Spiritual (10.5% of guests)	
Linked to or provided individual referral to non-religious organizations (eg. Yoga, Meditation)	66.7%
Linked to or provided individual with self-help literature	59.3%

The linkages facilitated and reported by staff seem to align well with the most common goals of Project Return guests. Additionally, staff reported that most of the linkages were successful. A successful linkage can be described as a linkage facilitated by a peer that the guest accomplishes. For example, a peer assists a guest with a housing assistance application while supporting their recovery goal to live independently. If the guest shares with peer staff

that they finished the application and submitted it; this would be considered a successful linkage.

Among the most common goals and linkages, more than 75 percent of linkages with housing resources and support were successful; 88 percent of linkages with emotional wellness self-help and education groups were successful. This indicates that the majority of guests reported attending self-help group sessions when peer staff facilitated the linkage. Many of the linkages were reported by staff as requiring follow-up, suggesting that some types of linkages may require more than 30 days to complete, or guests had not shared any further information about the linkages with peer staff.

IMPACT

Due to the short duration of the PRRCH intervention, it is difficult to identify the longer-term impact of the program on guests using a traditional repeated measures design. After leaving the respite, guests are often difficult to find for follow-up, further limiting the ability to observe long-term impact. As a result, several qualitative methods were used, including Provider Focus Groups and the Respite Study (see sidebar).

Staff noted in the Provider Focus Groups that Hacienda of Hope's impact on guests varied for each guest based upon their specific goals and needs. Guests interviewed for the Respite Study toward the end of their stay were asked to identify the impact of their stay at Hacienda of Hope. The areas of immediate impact most frequently identified by guests could be organized into two categorical themes: skill development and management of health issues.

Skill development: Guests shared that the respite helped them build relationship, coping, and anger-management skills through their experience staying at the respite, and provided them with exposure to many different people. Many guests had goals to improve their skills related to either daily life or interpersonal relationships, which led staff to refer guests to educational or support resources to help them. These areas of skill development fell into the Emotional and Social Dimensions of Wellness on the Linkage Tracker. The majority of guests with a goal in the Emotional or Social Dimensions of Wellness were linked with support groups (73.1% and 61.4%, respectively) or various skill building resources (14.3% and 22.7%, respectively). The linkages to support groups were almost always successful (87.4% and 92.3%, respectively), as were a majority of the educational resources (76.5% and 70.0%, respectively). In addition to being connected with resources to build skills, guests highlighted in the Respite Study that they learned new skills and developed more accurate self-awareness from other respite guests and the peer staff.

Provider Focus Groups

To directly inform this report, the evaluation team conducted Provider Focus Groups. These included four in-person focus groups with PRISM and PRRCH staff from each provider in the summer of 2015. For example, one focus group was with SHARE!'s PRISM staff and one with their PRRCH staff. Each Provider Focus Group included at least three staff people.

Respite Study

To explore short and longer-term outcomes for PRRCH guests, interviews with respite guests were conducted to learn why interview participants came to the respite, document their experience at the respite, and understand the respite's impact on them. Interviews were conducted with respite guests at both SHARE! and Project Return Peer Support Network, and were conducted by trained peer interviewers. Initial interviews were conducted toward the end of the guests' stay. Follow-up interviews were conducted three to six months after their stay was complete. Across both providers, 45 guests were interviewed for the study. Twenty-one of the guests interviewed stayed at Hacienda of Hope.

Guests also identified that through their interactions with other guests and staff, they were able to overcome social anxiety, and learned to communicate effectively. For example, one guest described how toward the end of their stay, these new skills and relationships positively impacted their life:

> *"I've been a recluse and a hermit type for over 18 years. Now, I'm functioning, I'll actually talk to people. Had it not been for this place, I don't think I would be open and receiving people and interacting normally. Because of this, it's kind of just put me in a mode to where when I go out of here. I like to talk to people now. Whereas, before I didn't. That's changed by being here."*

Managing health issues: Guests reported that their respite stay provided support and space so they could then begin to treat or manage physical and mental health challenges. For example, one guest described: *"The insomnia and the depression, anxiety, those types of things weren't being treated. Now it's being treated… Had it not been for Hacienda House, that wouldn't have been possible because my head wasn't clear. I was able to just think things through here."*

Another guest shared, *"I have liver disease and I'm set up now to where I'm going to start getting the treatment I need because I was able to sit down and plan my life to where I now make these appointments and I keep them."*

A key to anyone's long-term recovery is being motivated to improve one's wellness. That could entail finding the motivation to get more exercise to improve physical health or to stop using substances. Many guests reported that they found the motivation they needed at the respite.

> *"You got time to think, you don't have people telling you 'you got to go do this.' All the groups are voluntary, they encourage you to go but they don't make you. It's kind of like, if you're motivated. And this house will motivate you to want to do better."*

> *"…[when I first came to the respite] I was crying all of the time; I couldn't do anything when I got there. When I left I've been able to maintain. [I] go to my appointments that I have to go to and get up and do the stuff that I need to where I couldn't when I got there. I was just at the bottom. [Hacienda of Hope] really helped me a lot [Hacienda of Hope]…we're now living at the transitional living, we're able to go on again."*

Three to six months after staying at Hacienda of Hope, guests were interviewed again to learn about the longer term impact of their respite stay. After staying at the respite, people described being able to directly apply the skills they learned and stayed connected to the staff to better manage relationships and better handle relapse. For example, one former guest shared, *"…I thought about using because I wanted to get rid of…feelings. I called [respite staff] and she said, '[guest name] put your kids' pictures up. Look at your children. Get the boxes out of your stuff…' I got them up and I was able to not use. It was huge. It was huge. I was close…She said, 'You look at those pictures. Any time you get ready to use.' She said, 'That's what I do. I look at my kids' pictures.' It helped. From so many different ways, they assist."*

In addition to skill development and assistance managing health issues, guests who participated in the Respite Study emphasized the respite's role in helping them improve their housing situation. Although the PRRCH programs were initially designed to serve only guests who had a permanent address (i.e., who were not homeless), many Project Return guests were homeless when they entered the respite. This is likely due to the high percentage of homeless veterans in the Villages of Cabrillo where the respite is located. Guests highlighted that the respite helped them successfully link to housing and specifically to a pilot housing program with Cabrillo Gateway apartments. Cabrillo Gateway apartments provide 80 permanent support homes for families across its mix of one, two and three bedroom apartments. All homes are subsidized with a project-based voucher through the Housing Authority of the City of Long Beach. Sixteen homes are being set aside for families that qualify under the MHSA housing program. Resident services are provided by resident service coordinators from CVC's Oasis Community Center. Additional specialized services are made available by LACDMH and The Children's Clinic, which is operating on the ground floor health clinic.

As previously noted, housing was the most common guest goal as reported on the Linkage Tracker (34.7% of guests described housing as a goal, and 49.8% of guests had a goal in the Environmental Dimension of Wellness). While relatively few guests (14.8%) with a housing goal were linked with an application for a housing assistance voucher program, such as Section 8, this was the most successful Environmental linkage (89.5% of guests). Additionally, linkages to both specific housing resources and education/life skills support group on maintaining independent living showed similar success (76.7% on average and 78.8%, respectively).

Although the evaluation was primarily focused on understanding the impact of the respite on guests, staff reported during the Provider Focus Groups that they themselves experienced benefits from their experiences working with

guests. As one staff person shared, *"I've learned that we're all kind of the same but different. We all have [a] similar story of rocky history or need support. I have learned how far I have come through my own recovery and my family's recovery."*

SATISFACTION

The guest-completed Feedback Survey was administered to contribute to our learning about guests' experiences with the peer-run respite, and to help staff make ongoing quality improvement plans to ensure guests benefit from the support and recovery environment. In general, satisfaction with the Project Return PRRCH program, as reported on the Feedback Survey, was high. Most guests agreed that they liked coming to the program (97.7%), and would still come to the program if they had other choices (93.6%). Almost guests agreed that they felt safe at Hacienda of Hope (96.5%) and that there are people available to talk with as often as they felt was necessary (95.3%). Guests also agreed that the program respected their cultural needs (93.5%) and beliefs about health and well-being (94.7%). The majority of guests agreed that the program helped them feel empowered to make positive changes in their life (94.2%). Most guests also agreed that their mental health, physical health and substance use concerns were addressed by Project Return (90.6%).

Guests interviewed as part of the Respite Study also noted that they were satisfied with their stay, with most sharing that they would recommend the respite to a friend with similar issues or challenges. Across guests interviewed, most felt that the peer staffing and support was integral to their satisfaction with the program and to the program's positive impact. Many guests felt that the unique nature of the relationships they formed with staff was instrumental in their success. *"I love the relationship with the staff…I would recommend this place off the top. If you want to get away from home, yes, go to the Respite. You will feel safe, you'll feel loved, you'll feel welcomed and that's what I felt."*

Another guest shared, *"The staff, that's therapeutic because they talk to you, you can be open with them. It's like having your own private therapist. Everyone that I talk to that works here, therapeutically helps…it's just natural. You're in the kitchen, or you're playing dominoes, cards. They play games with you and will sit and talk to you forever as long as you talk, you can discuss something. It's like having your own personal therapist here."* Guests appreciated staff's non-judgmental and lived-experience perspective.

However, guests were less likely to agree with some items on the Feedback Survey. Guests were least likely to endorse the Feedback Survey item, "Participating in this program has made me more effective in my relationships with family and friends" (69.4%). This contradicts the experience of guests interviewed as part of the Respite Study. At both the end of their stay and several months after their stay, guests expressed that the respite helped them build relationships and strengthen coping skills. It is possible that guests' responses were influenced by the inclusion of the word 'family' in the question.

In the Respite Study interviews, guests expressed two areas of dissatisfaction with the respite: they wished the respite had more structure, and they wanted the stay to be longer. Related to structure, people interviewed wanted more programming in the evening, and more classes and activities that included physical activity. As one person shared, *"There's like three groups right in a day and I think that's quite a bit…[The] only problem was like at night time, sometimes I would be looking for something to do."* While guests appreciated the 30-day stay, they also shared that they needed more time to fully benefit from the respite. As one person noted, *"I feel 27 days, sometimes, is not enough time, because you're just barely getting in the hang of things, and getting into enjoying all these programs and things they offer."* This supports the notion that agreement ratings on the "helpful referrals and resources" item on the Feedback Survey might be higher if guests had more time to set goals, find referrals, and make connections. However, it is important to note that some aspects of the respite were purposely not as structured to empower the guests and that the 30 day time period was a scope of work constraint set by LACDMH.

Project Return PRRCH Guest Feedback Survey			
	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
I like coming to this program.			
Baseline Assessment (N=173 Guests)	0.0%	2.3%	97.7%
If I had other choices, I would still come to this program.			
Baseline Assessment (N=173 Guests)	1.2%	5.2%	93.6%
People were available to talk with me as often as I felt it was necessary.			
Baseline Assessment (N=172 Guests)	1.2%	3.5%	95.3%
I feel safe when I am at this program.			
Baseline Assessment (N=171 Guests)	1.2%	2.3%	96.5%
As a result of this program I feel empowered to make positive changes in my life.			
Baseline Assessment (N=171 Guests)	1.2%	4.7%	94.2%
This program helps me reach my goals.			
Baseline Assessment (N=171 Guests)	1.8%	7.6%	90.6%
This program respects my cultural needs (race, religion, language, etc.).			
Baseline Assessment (N=170 Guests)	1.2%	5.3%	93.5%
My mental health, physical health, and substance use concerns are addressed.			
Baseline Assessment (N=170 Guests)	0.6%	8.8%	90.6%
My beliefs about health and well-being were respected in this program.			
Baseline Assessment (N=171 Guests)	0.0%	5.3%	94.7%
I have found referrals to resources that assisted me and/or my family.			
Baseline Assessment (N=172 Guests)	1.7%	16.9%	81.4%
I participated in the decision making about my recovery and wellness.			
Baseline Assessment (N=172 Guests)	1.7%	7.0%	91.3%
As a result of this program, I deal more effectively with daily problems.			
Baseline Assessment (N=172 Guests)	0.6%	12.2%	87.2%
Participating in this program has made me more effective in my relationships with family and friends.			
Baseline Assessment (N=170 Guests)	2.9%	27.6%	69.4%
After coming to this program, I am better able to work towards my life goals.			
Baseline Assessment (N=169 Guests)	1.2%	10.7%	88.2%
I feel comfortable talking about personal matters with peer staff.			
Baseline Assessment (N=171 Guests)	1.2%	8.8%	90.1%
I participate in activities with others in the community of my choice.			
Baseline Assessment (N=171 Guests)	2.3%	11.1%	86.5%

SHARE!

PROGRAM DESCRIPTION BASED ON PROVIDER PERSPECTIVES

SHARE!'s PRRCH program–the Recovery Retreat–is described by staff as a boot camp or jump start for recovery. Staff noted that it is a *"place where people feel supported in learning and growing in their own process, and getting connected to tools that are helpful to them, such as support groups."* Staff describe the retreat as a place where people are supported to take charge of their lives, create and strengthen their social networks, identify and pursue their goals, and learn that they have all the resources they need to handle life's challenges. While staying at the retreat, guests learn life skills such as conflict resolution, communication skills, budgeting, shopping, and cooking. Guests have their own private bedrooms and can stay at the retreat for up to two weeks. There are eight beds at the SHARE! Recovery Retreat, and generally there are five to eight people staying at the retreat at a time. The retreat exclusively serves women for two weeks, and men for the next two weeks. Staff noted that this format supports the limits of how long someone can stay at the retreat without staff having to take on an authoritative stance.

The retreat is focused on balancing structure and flexibility. It has four rules: 1) no unlawful activities, 2) no smoking in the respite, 3) everyone's belongings are heat treated for bedbugs at move-in, and 4) no one can be at the respite alone. Each two week stay begins with a group meeting during which guests decide on the house rules and make plans for accomplishing group activities, such as meals and house chores. Each group of guests creates their own house rules and runs the respite together. Guests also develop plans for how to handle situations such as when someone loses their sobriety or disobeys the house rules.

At a daily house meeting, which is not attended by staff, guests decide on the food menus for the day, who will do what chores, which self-help support group they will attend that night, and who will serve as "house leader" that day. The guests shop for and cook every meal together, and each person does daily chores. Every morning people complete a five year goal sheet, and every afternoon recovery activities are offered. Every night guests attend different support groups such as Recovery International meetings and Alcoholics Anonymous meetings, Emotions Anonymous, Co-Dependents Anonymous, and Narcotics Anonymous. Activities are intended to help people establish daily structure and resources that they can use once they leave the retreat.

Guests design their own Wellness Recovery Action Plan (WRAP) that they can use to get well, stay well, and make their life the way they want it to be. The WRAP includes their preferred medical and mental health treatment, and developing a greater awareness of their existing support network of friends and family. People establish weekly and daily plans for life after they leave the retreat, and are linked to support groups within their community.

A key aspect of the retreat is learning to get along with others and maintaining relationships through conflict, disappointment, and disagreement. Therefore, a core component of the retreat is developing new skills, including conflict resolution, cooking, and budget management. For example, as a group, guests must budget, plan, shop for, and prepare meals using the four dollar per person per day meal budget. Staff shared that each group of guests typically goes through several stages of building a team over the course of their stay: forming, storming, norming, and performing. Staff provide support and model conflict resolution skills to work through those stages. As one staff person noted during Provider Focus Group interviews: *"By the end of week one, we are in the storming stage. When they first come in, it's the honeymoon stage. By the end of week one, they hate everyone. I help to normalize that; it is normal that you are having conflict. We help people address conflict. I explain what peer support is; I'll help you but I'm not going to fix it for you; I'll offer suggestions. I'll suggest that they have meetings. Most of the time they have meetings without me and it gets resolved."* Respite staff are there to support and empower guests; They are not there to enforce rules or solve problems.

Outreach and Engagement: Outreach is targeted to current SHARE! participants, mental health facilities in the community, psychiatric hospitals, Coordinated Entry System, National Alliance on Mental Illness (NAMI) groups, and faith-based organizations. Staff also regularly go to the service area meetings in LACDMH Service Planning Areas 4, 5,

6, and 7. The program also receives referrals from NAMI groups. Staff shared that most people come to the retreat through word of mouth from someone involved with SHARE! or someone who has stayed at the retreat. Several guests (5.4%) were referred to the Recovery Retreat from SHARE!'s PRISM program.

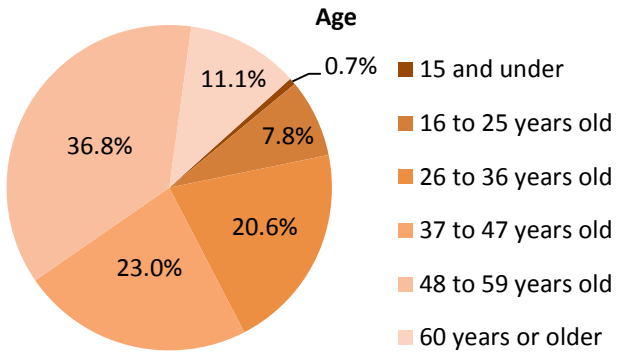
SHARE! has a Recovery Retreat application that everyone must complete before staying at the respite. Staff noted that the application process is also an opportunity for them to share more about the respite and define recovery. The application for the SHARE! Recovery Retreat has been used since the beginning. It was updated in the first year to include a more complete description of the daily schedule so guests would have an idea what to expect. Staff highlighted that the application process helps people build accurate expectations for their stay at the retreat. However, when most people come to the retreat, staff noted that they still expect specific rules and for the staff to do things for them. As one staff person noted, *"They are expecting staff to create the rules so it is important to acclimate them to what peer support is. We help people through the first house meeting and slowly step back as they start to take over."*

GUEST CHARACTERISTICS

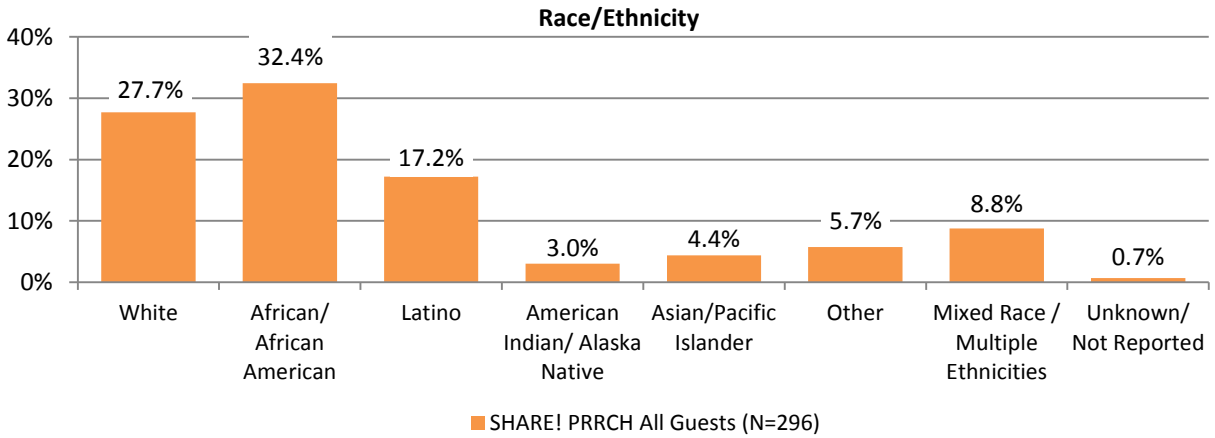
The Recovery Retreat serves people with mental health concerns and people who want to know more about recovery. Staff shared that some guests are dealing with a specific crisis in their lives, such as a death in their family or depression. Staff noted that people are typically guarded at the beginning of their stay, and do not want to connect with other people. Staff act as a bridge to help them connect with others. Staff shared that the retreat is the best fit for people who have their own housing, and are interested and willing to grow as a person. People interviewed for the Respite Study reported that they came to the respite as a way to get away from their current situation and to focus on a healthier lifestyle, to learn new skills, and receive support from other people.

To date, 296 guests have stayed at the Recovery Retreat. Almost fifteen percent (14.9%) of guests had multiple stays at the Recovery Retreat. The most common reasons for returning to the program are an acute substance use crisis/relapse and/or acute mental health crisis/relapse.

Guests who stayed at SHARE! were most likely to be between the ages of 48 to 59 (36.8%). A very small percentage of guests (0.7%) were 15 years old or younger.



Guests were most likely to identify as African/African American (32.4%) and White (27.7%).



Illness Management and Recovery (IMR): Staff Assessment of Mental Health

Staff are asked to complete the IMR Scale for each guest to assess recovery from the perspective of the peer staff member. The IMR can help staff identify specific areas that they feel may be challenges to the guest, as well as highlight other domains that may be potential strengths that can support their recovery. It also provides a way to understand where guests are in their recovery process, on average, when they came to the respite. The IMR has 15 individual items, which, when averaged, make up an Overall score and three subscales: Recovery, Management, and Substance Use. IMR scores range from one to five, and lower scores indicate a guest is doing well in a particular domain or subscale.

SHARE! PRRCH IMR Subscale Scores	
Recovery Subscale ***(mean of items 1, 2, 4, 8, & 12)***	**2.62 (N=255)**
Management Subscale ***(mean of items 6, 7, 9, & 11)***	**3.49 (N=255)**
Substance Use Subscale ***(maximum of items 14 & 15)***	**2.89 (N=255)**
Overall IMR Score ***(mean of items 1-15)***	**2.92 (N=255)**

Mental Health Status

The table to the left shows mean (average) Overall IMR scores, and Recovery, Management and Substance Use Subscale scores. The average scores indicate that SHARE! guests were experiencing more difficulty with self-management when they enrolled in the PRRCH program than with coping with their mental health and/or wellness and substance use.

Guest Reported Mental Health

Peer staff wanted to assess guests' feelings of self-efficacy. Together, the evaluation team and peer staff developed two items to assess this domain. SHARE! guests were asked about their self-esteem and sense of control on the Feedback Survey. More than half of SHARE! guests reported having high level (ratings between 6 and 10, on a scale of zero to 10) of self-esteem (63.7%). Most guests reported feeling either some control (25.9%) or a high level of control over their life (ratings between 7 and 10, on a scale of zero to 10) during their stay (56.5%).

Please rate your current level of self-esteem using the scale below. (N=190 Guests)										
Very low	1	2	3	4	Average	6	7	8	9	High
1.6%	1.1%	2.1%	4.2%	9.5%	17.9%	8.9%	13.2%	15.8%	10.0%	15.8%

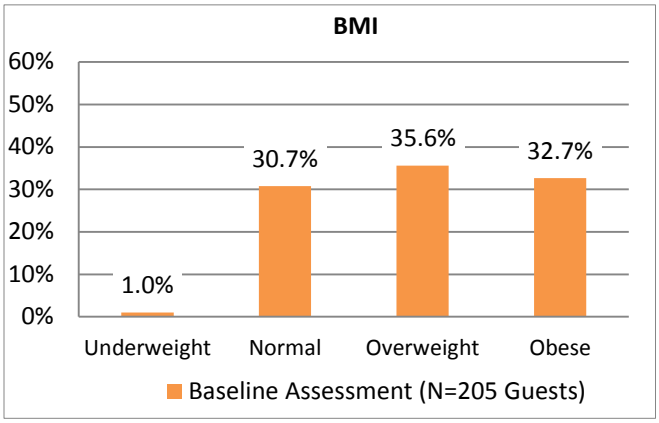
Please rate how much control you have over your life using the scale below. (N=189 Guests)										
No control	1	2	3	4	Some control	6	7	8	9	Complete control
0.5%	1.6%	3.2%	3.2%	2.6%	25.9%	6.3%	15.3%	11.6%	9.0%	20.6%

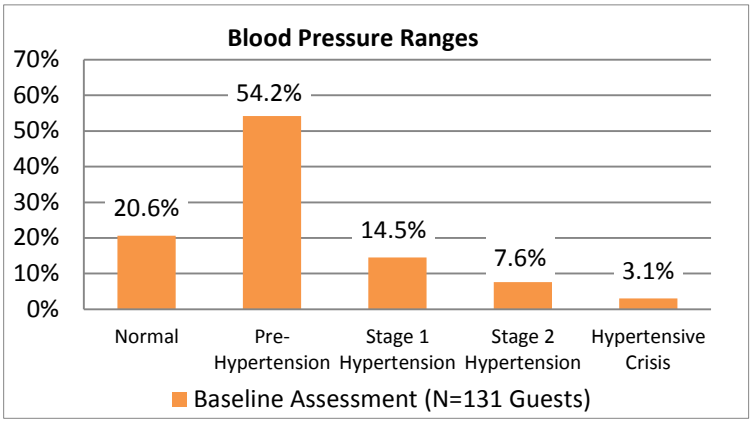
Guest Reported Physical Health Indicators

To get a basic picture of each guest's physical health, guests are encouraged to record their height and weight (to determine body mass index or BMI), and measure their systolic and diastolic blood pressure using blood pressure cuffs available at the PRRCH house. Guests' height and weight are used to calculate their BMI, a common method of determining whether an individual is at a healthy weight. Categories for BMI were determined using the standards published by the Centers for Disease Control (CDC). Systolic and diastolic readings were combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. These blood pressure categories, used in the table below, only reflect guests' risk for hypertension; additional criteria must be met for a diagnosis of hypertension.

Health Status

In general, SHARE! PRRCH guests had BMI's fairly evenly distributed among normal, overweight and obese categories. The majority of guests at SHARE! had pre-hypertension blood pressure (54.2%).





GOALS AND ACTION PLANNING

Early in the stay, each guest identifies his or her five year goals. This activity is intended to encourage guests to think about what success in their recovery would look like in five years as well as in annual increments. As one staff person shared, through this activity "*they get a pathway to succeeding at that goal and that is very powerful for people. They see that there is a possibility*." Support groups are a central part of the Recovery Retreat. Based on goals, interests, and needs, staff help match people with self-help support groups that are close to where they live so that they can continue in the same group after leaving the retreat. Guests have the opportunity to attend different support groups every day. While staying at the retreat, people attend support groups on-site, at SHARE!'s downtown facility, and throughout the community.

Linkage Tracker

The Linkage Tracker was developed for the peer programs to document guests' goals, linkages, and/or assistance support to achieve their goals, and the success of each linkage as reported by peer staff. The form was designed to align with the Eight Dimensions of Wellness identified by Substance Abuse Mental Health Services Administration's (SAMHSA). It includes the emotional, physical, environmental, social, occupational, financial, intellectual, and spiritual aspects of a person's life. These Dimensions of Wellness may help people better manage their concerns and experience recovery.

The most common goal expressed by guests and reported by peer staff on the Linkage Tracker were to strengthen their recovery path and improve their mental health and emotional wellness, including symptom management, coping skills, and anger (33.2%). Several guests also had goals to stop using alcohol and/or drugs and remain sober (16.8%). Many guests were seeking better support, and had goals to improve their relationships, form new friendships with individuals that are also in recovery and find support groups and a recovery community (23.6%).

Unlike case managers, who generally provide clients with specific referrals or resources, SHARE! staff empower guests to work toward the goals that they establish for themselves and then as requested connect them with resources to help support their work toward their goals.

On average, most guests (49.8%) had goals in one dimension (out of a possible eight) that they wanted to achieve during their stay. Guests were most likely to have a goal in the Emotional Dimension of Wellness (67.6%). The table below shows the most common linkages peer staff and guests discussed within each Dimension of Wellness, as well as how often staff facilitated each linkage. While this table describes the most commonly made linkages, it is not an inclusive list of all the linkages that staff may have discussed with guests. Staff may have discussed more than one linkage with a guest. It is important to note that (1) guests may have recovery or life goals in several different Dimensions of Wellness and (2) some guests may not have discussed any goals with staff upon first visiting a program.

The linkages facilitated and reported by staff seem to align well with the most common goals of SHARE! guests. Additionally, staff reported that most of the linkages were successful. A successful linkage can be described as a linkage facilitated by a peer that the guest accomplishes. For example, a peer assists a guest with a housing assistance application while supporting their recovery goal to live independently. If the guest shares with peer staff that they finished the application and submitted it; this would be considered a successful linkage.

Linkages to emotional or social skills self-help groups were the most common linkages recommended, and the most successful. Among the most common goals and linkages, 92.1% of linkages with substance abuse recovery self-help groups, 97.0% of linkages with emotional wellness self-help groups, and 100% of linkages with education or support on emotional wellness and social skills were successful. This indicates that almost all guests reported attending self-help group sessions when peer staff facilitated the linkage.

SHARE! PRRCH Linkage Tracker	
Most common linkages discussed with guests based on their goals (N=253)	**How often was linkage made (% guests)**
Physical (30.0% of guests)	
Linked individual to substance abuse recovery self-help group	84.2%
Environmental (15.4% of guests)	
Linked or provided individual education or support maintaining independent living	20.5%
Linked individual with transitional living program	23.1%
Emotional (67.6% of guests)	
Linked individual to emotional wellness self-help group	98.8%
Linked or provided individual education or support on emotional wellness	64.9%
Social (33.2% of guests)	
Linked individual to social skills self-help group (eg. Conflict resolution, communication)	94.0%
Linked or provided individual education or support around social skills	66.7%
Occupational (8.7% of guests)	
Linked to or provided individual assistance in searching/applying for jobs	31.8%
Linked to or provided individual workplace skills class or support group	27.3%
Linked to or provided individual assistance editing or creating a resume or cover letter	22.7%
Financial (5.1% of guests)	
Linked to or provided individual counseling on money management class or group	53.8%
Intellectual (4.7% of guests)	
Linked to or provided individual support to explore volunteer opportunities	83.3%
Spiritual (9.9% of guests)	
Linked to or provided individual with self-help literature	80.0%
Linked to or provided individual referral to non-religious organizations (eg. Yoga, Meditation)	64.0%

IMPACT

Due to the short duration of the PRRCH intervention, it is difficult to identify the longer term impact of the program on guests using a traditional repeated measures design. After leaving the respite, guests are often difficult to find for follow-up, further limiting the ability to observe long-term impact. As a result, several qualitative methods were used, including Provider Focus Groups and the Respite Study (see sidebar).

Social support: Many guests had goals to improve their interpersonal relationships, which led staff to link guests with support resources to help them. These referrals fell into the Social Dimension of Wellness on the Linkage Tracker. The majority of guests with a goal in the Social Dimension of Wellness were linked with self-help support groups (72.5%), and almost all of these linkages were successful (97.4%).

In the Provider Focus Group, staff highlighted that staying at the respite had a positive impact on guests' relationships and social support. Close friendships were forged among guests, and guests often exchanged phone numbers so that they could stay in touch. Staff also highlighted how the skills that guests learned at the respite helped them improve relationships with their families to rebuild their support networks.

Guests interviewed as part of the Respite Study also mentioned the benefit of the social support received both from the other guests and from the peer staff. As one person interviewed shared, *"It's just the confidence, being among other people, to interact with them. I was really isolated, but it's given me the opportunity now to be able to speak with other people who are like I said, in similar circles. Even people who aren't in a similar circle, it allows me to express myself better."* Another interviewee noted, *"Every staff impacted me with their story. Every which one of them. All the staff that works here has sat down in our morning group, got to know us, spend some time with us, had breakfast with us, had lunch, had dinner with us, we've prayed together, the staff along with us and that is amazing to me."*

Provider Focus Groups

To directly inform this report, the evaluation team conducted Provider Focus Groups. These included four in-person focus groups with PRISM and PRRCH staff from each provider in the summer of 2015. For example, one focus group was with SHARE!'s PRISM staff and one with their PRRCH staff. Each Provider Focus Group included at least three staff people.

Respite Study

To explore short and longer-term outcomes for PRRCH guests, interviews with respite guests were conducted to learn why interview participants came to the respite, document their experience at the respites, and understand the respite's impact on them. Interviews were conducted with respite guests at both SHARE! and Project Return Peer Support Network, and were conducted by trained peer interviewers. Initial interviews were conducted toward the end of the guests' stay. Follow-up interviews were conducted three to six months after their stay was complete. Across both providers, 45 guests were interviewed for the study. Twenty-four of the guests interviewed stayed at SHARE!'s Recovery Retreat.

Self-worth: Staff shared in the Provider Focus Group that they saw an increase in people's sense of self-worth and self-love. For example, one staff person shared, *"One man that came in was homeless and really depressed. The first few days he spent alone in his room. His sense of self-worth was destroyed. By the end of the retreat his life was transformed. Because we believed in him he believed in himself. He is a known musician. We called his brother to check up on him; his brother raved about SHARE!, 'In 20 years I haven't seen my brother like this.' Those 2 weeks it was an incredible story. By letting everyone do everything for themselves and doing it in a group, it allows them to see 'I can too'. By the time they have gone through the routine for 14 days it's like 'I can go shopping.' 'I can really stop drinking now.'"*

Guests interviewed as part of the Respite Study also reported that the retreat impacted their self-confidence and self-worth. As one person shared at the end of her stay at the retreat, the respite gave her the confidence to stand up for herself and get out of a bad relationship:

> *"My boyfriend was not supportive. He smokes weed. He drinks excessively. He has already put his hands on me a few times. We've had some physical altercations. He takes a lot of my money. He treats me like shit, to be quite frank. I was being honest about this. Other ladies, four ladies who are here other than me, they're all*

like mid to late 40s to 50s. They were able to give me some insight about the reality of the situation I was in. They gave me the courage to let him go and break up and move forward with my life. So I don't have to be beat on or encouraged to be smoking or anything of that nature."

Skill development: Both staff and guests shared that the retreat built people's life skills and interpersonal skills. People interviewed noted that they learned specific skills as part of self-help groups and other retreat activities, as well as through interactions with other guests. As one person noted, *"I never knew that everyone had mental issues that are similar to mine. I learned a lot of coping skills here throughout every day we do meetings, we do group meetings, house meetings and we also do NA [Narcotics Anonymous], different types of meetings for issues that I have."* People interviewed shared specific examples of how they applied the new interpersonal skills they developed during their time at the respite. For example, one person interviewed several months after leaving the respite shared:

"The girl shouted at me. If I wouldn't have picked up what SHARE! taught us about stop, drop and think, I'd probably would have grabbed her and shook her around, but this happened after I learned [skills at the retreat]. Then, she hollered in my face and I just used those tools… later on she came back and apologized to me, and today I use those tools. That's the biggest impact, the biggest thing I learned from SHARE! That's very important to me because I've been in prison a lot for being angry and being aggressive and that was one of the main things that I appreciate that I learned."

Other people highlighted how the recovery and coping skills learned at the respite were important after experiencing a relapse. For example, one person said, *"I relapsed and instead of beating myself up, [I said] 'Oh, well screw it, I messed up so might as well just keep on going.' I thought back to the groups that I attended and what I got…they told me that it's okay, you know, we're human, you know…When I relapsed, I thought about SHARE! and what was said about, you know, don't give up, take it day by day, so that's when I decided to pick myself back up, due to SHARE!"*

SATISFACTION

The guest-completed Feedback Survey was administered to contribute to our learning about guests' experiences with the peer-run respite, and to help staff make ongoing quality improvement plans to ensure guests benefit from the support and recovery environment. In general, satisfaction with the Recovery Retreat was high. Most guests agreed that they liked coming to the program (96.4%), and felt safe at SHARE! (90.0%). The majority of guests agreed that there were people available to talk with as often as they felt was necessary (91.5%). Guests also agreed that the program respected their cultural needs (92.7%) and beliefs about health and well-being (92.6%). Almost all guests agreed that they participated in decision making about recovery and wellness (95.2%), and most guests also agreed that their mental health, physical health and substance use concerns were addressed by SHARE! (92.5%).

Guests interviewed as part of the Respite Study also noted that they were satisfied with their stay, with most sharing that they would recommend the respite to a friend with similar issues or challenges. For example, one person stated, *"If you want the help, the help is here for you. If you want to heal, it's here. It's whatever you want. If you want to come to the program and retreat, and get yourself together…you could work it, because they're going to help you. If you believe in yourself, and believe that it's going to help, they're going to be here to help you all the way…They're going to have your back. I feel safe here."*

Guests interviewed also shared that they appreciated the candor of the peer staff with regards to their own recovery, and were inspired by their success. *"When you see them [peer staff] in the same recovery process, you know it's doable. We got a chance to meet some people that have 14 years clean, and were able to really expound upon why you can go to any meeting, and you can come away with something."*

However, guests were less likely to agree with some items on the Feedback Survey. Guests were least likely to endorse the item "I have found referrals to resources that assisted me and/or my family (75.8%)." A goal of peer staff is to empower guests to find resources and linkages themselves, rather than relying on staff to be a problem-solver. Finding resources is dependent on the guest's motivation and not the program. After noticing the low satisfaction on

this item, which SHARE! staff expected to be higher, they implemented a new procedure for implementing Wellness Recovery Action Plans (WRAP). Peer staff believe that this will better meet the guests' needs, thus improving satisfaction ratings. A future evaluation report will determine whether scores improved after implementing the new procedure.

Guests were also less likely to endorse the Feedback Survey item, "Participating in this program has made me more effective in my relationships (78.4%)." This contradicts the experience of guests interviewed as part of the Respite Study. At both the end of their stay, and several months after their stay, guests expressed that the respite helped them build relationships and strengthen coping skills, with some highlighting direct positive impact on interpersonal relationships. It is possible that guests' responses were influenced by the inclusion of the word 'family' in the question.

In the Respite Study, guests expressed one area of dissatisfaction with the respite: they wished the respite had more structure from peer staff. Specifically, most guests interviewed said that they wanted peer staff to enforce rules more regularly. For example, one person was disappointed with the lack of rules regarding personal hygiene.

> *"They say they're going to teach people life skills, but they won't talk to this person to try to improve at all…What kind of person is going to be here [for many] days without showering or changing their underwear or clothes. We have to smell them…we were sitting at the supper table, and it smells nice, and then the person comes by and stinks like a homeless person…worst of all is that the staff won't apply any pressure. The peers hadn't talked to him for days until he finally agreed to take a shower. The staff didn't even say a word."*

It is important to note that SHARE! purposely structured the respite to be led by the guests with staff as social support and not there to create or enforce rules. Specifically, SHARE! staff believe that empowerment comes from solving problems on one's own. Guests may have been frustrated in part because they were unclear about what to expect from the respite. This included how the respite is organized and that it is peer-run. Guests interviewed shared that they were also unprepared for the wide range of guests that the respite is designed to accommodate. One person shared:

> *"I expected it to be a house full of people with mental problems, and/or addiction or alcoholic problems…I did not realize it was like a peer-run thing…I did not realize that all the people here are basically like us, except they have more experience in recovering from their mental health and/or alcoholic addiction, due to more time sober or more time around SHARE!, or around programs like this…I thought there would be a nurse or a doctor coming by once a day."*

Overall, guests interviewed were unclear about what to expect from the respite including who it serves, the environment, and staff's roles. As one person noted, *"I thought it was different. I thought it was like a resort where you have fun, or where you do different kinds of activities. I thought, like a holiday resort."*

SHARE! PRRCH Guest Feedback Survey			
	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
I like coming to this program.			
Baseline Assessment (N=192 Guests)	1.6%	2.1%	96.4%
If I had other choices, I would still come to this program.			
Baseline Assessment (N=191 Guests)	5.8%	8.9%	85.3%
People were available to talk with me as often as I felt it was necessary.			
Baseline Assessment (N=188 Guests)	3.2%	5.3%	91.5%
I feel safe when I am at this program.			
Baseline Assessment (N=190 Guests)	3.2%	6.8%	90.0%
As a result of this program I feel empowered to make positive changes in my life.			
Baseline Assessment (N=191 Guests)	2.1%	6.8%	91.1%
This program helps me reach my goals.			
Baseline Assessment (N=192 Guests)	4.2%	9.9%	85.9%
This program respects my cultural needs (race, religion, language, etc.).			
Baseline Assessment (N=191 Guests)	1.0%	6.3%	92.7%
My mental health, physical health, and substance use concerns are addressed.			
Baseline Assessment (N=186 Guests)	2.2%	5.4%	92.5%
My beliefs about health and well-being were respected in this program.			
Baseline Assessment (N=190 Guests)	1.6%	5.8%	92.6%
I have found referrals to resources that assisted me and/or my family.			
Baseline Assessment (N=190 Guests)	8.9%	15.3%	75.8%
I participated in the decision making about my recovery and wellness.			
Baseline Assessment (N=187 Guests)	1.6%	3.2%	95.2%
As a result of this program, I deal more effectively with daily problems.			
Baseline Assessment (N=190 Guests)	2.6%	15.3%	82.1%
Participating in this program has made me more effective in my relationships with family and friends.			
Baseline Assessment (N=190 Guests)	4.7%	16.8%	78.4%
After coming to this program, I am better able to work towards my life goals.			
Baseline Assessment (N=186 Guests)	2.7%	11.3%	86.0%
I feel comfortable talking about personal matters with peer staff.			
Baseline Assessment (N=189 Guests)	5.3%	7.4%	87.3%
I participate in activities with others in the community of my choice.			
Baseline Assessment (N=188 Guests)	2.7%	13.3%	84.0%

PRRCH MODEL DISCUSSION

Overall, PRRCH guests were very diverse, and in several ways they were similar to clients from the other INN models. Guests represented a wide range of ages and ethnicities. Compared to the other INN models, on average, SHARE! served guests with greater substance use issues than clients in the ICM or ISM models as reported on the IMR and PROMIS-Derived Substance Use Scale. Project Return served guests with similar substance use issues to ICM and ISM models. The overall mental health of PRRCH guests as recorded on the IMR was less impaired than for clients from the other models, while physical health was comparable. The engagement of guests who were suffering from serious health concerns, and the positive impact described by both staff and guests indicates that this model is a viable alternative to traditional healthcare, or a gateway into the healthcare system.

Peer model supervisors at LACDMH believe that the implementation successes and lessons learned through the PRRCH model support opening more respites within Los Angeles County. During the Provider Focus Groups, staff from each respite shared the primary implementation challenges, how they were overcome, and suggestions for how to most effectively continue the respites. Because there were many similar challenges and suggestions across providers, their responses have been combined below.

Hiring and Training Staff: During the Provider Focus Groups, staff from both programs shared that they had difficulties either hiring qualified peer staff, or maintaining consistent staffing. Peer model supervisors at LACDMH also noted these challenges in their interviews. SHARE! staff felt that building a team of staff large enough to operate for 24 hours a day, seven days a week was a significant early challenge. They noted that the typical hiring time period of 90 days for new LACDMH projects is not enough time to find and train peer staff. Early in the program, SHARE! guests had to go home on the weekend since there was not enough staff to run the respite. During the hiring phase, some existing staff had to work very long hours and double shifts to keep the respite open. Peer model supervisors at LACDMH reported that the peer providers regularly discussed their staffing challenges at monthly peer roundtable meetings. They sought to fully understand this issue in order to best support the peer programs. Several qualities were highlighted as vital for a successful peer staff member:

- Having lived experience (for management/leadership to support staff, and for all other staff to support guests)
- Experience in the mental health field
- Experience attending self-help groups for at least one year
- Experience attending a respite as a guest in the past is beneficial

Both providers also highlighted the need for additional trainings from LACDMH. They wanted trainings to be offered early in the program and frequently to accommodate new hires. Additionally, they requested hosting trainings at the respites to make trainings more accessible for staff. It was impossible for all staff to attend an off-site training while keeping the respite open. Several essential trainings listed included:

- Intentional Peer Support (IPS) training to develop the skills and the mindfulness to be an effective peer in these programs
- Peer Advocate Certificate training
- Wellness Recovery Action Plan (WRAP) training

Hiring and training of leadership was especially important for staff at Project Return. The provider had several rounds of turnover at the leadership level, and staff shared during the Provider Focus Group that when the respite began, they felt little support or direction from their leadership. In addition, they believed that prior leadership was unsupportive, which made implementing the respite challenging for them as staff. As a result, staff stressed the importance of clear direction and support from leadership. They also felt that weekly team meetings helped ensure that everyone has a shared understanding and common direction. Peer model supervisors at LACDMH also noted the challenges from the leadership and organizational changes at Project Return. They also highlighted the impact of the

organization's transition to become a separate legal entity from Mental Health America – Los Angeles. Overall, peer model supervisors emphasized the importance of carefully considering staffing needs prior to implementing a peer program, and providing ample time to find and train peer staff as an important lesson for other counties and programs to consider. Counties need to recognize the unique staffing needs of peer programs and understand how organizational changes can impact the program and its staffing. Until comprehensive peer training is available, programs may require additional time to train staff to be able to work in their programs.

Length of Stay: In planning their programs, each provider initially designed the PRRCH program to last for approximately two weeks. SHARE! enforced this limit by transitioning the house from all male to all female every two weeks. While Project Return also designed their program for one- to two-week stays, staff shared during the Provider Focus Groups that it was hard for most people to accomplish their goals in that short time. As a result, the program has purposely become more flexible about how long people can stay at the respite, and many stay for the full 29 days. However, the staff learned to not tell people that they can stay for 29 days when they enter the respite. They have found that if people know how much time they have, they will not quickly prioritize working on their goals. Instead, staff talk with guests throughout their stay to reassess their progress towards their goals and adjust the length of stay up to the full 29 days if needed. Project Return staff stressed that limiting stays to only one week would make it difficult for guests to get all of the support and resources they need and want. Guests interviewed as part of the Respite Study also appreciated the longer stay options; however, they felt that even 30 days was not long enough to complete their goals.

Structure of the Program: Each respite purposely offered a different amount of structure for guests. In the Provider Focus Groups, SHARE! staff reported that guest activities and the daily schedule changed since implementation. Initially, guests participated in Recovery International support group meetings every morning and afternoon. However, over time staff shared that they realized they had to let the day be less structured. They shifted to meditation in the morning and then offered a suggested schedule for the rest of the day (for example, by deciding as a group when to go shopping). Guests can make their own schedule for the day, providing a flexible structure. While SHARE! had some structured group activities as determined by guests, Project Return had relatively unstructured days for their guests. Staff and guests had breakfast together, and then guests spent much of the day on their own attending support groups or working on their goals. The guests then came together again for dinner. In the Respite Study, guests noted that this freedom was one of their least favorite aspects of the respite. Guests from both programs wanted more structured days as well as more physically active activities, and guests at Project Return wanted more activities at night.

Integration: In the Provider Focus Groups, staff from both programs described how peer staff should be more integrated into the overall system of care, and provide more input in treatment plans. Peers could be cost efficient by freeing up other staff time and reducing burden on the system. Many LACDMH programs currently incorporate peer services, including other INN models of care and Community Services and Support (CSS) programs, such as Full Service Partnerships (FSPs). The peer staff suggested that peers could perform the following activities:

- Providing social support for clients, which can be challenging for case managers with large caseloads. As one staff person shared in the Provider Focus Group, *"We have seen that not having that social support brings greater mental health issues, greater deaths when you don't have those peer services. It is still essential."*
- Finding appropriate linkages and referrals for clients
- Helping clients improve their quality of life and become less dependent on the system (including welfare, emergency rooms, shelters, etc.) by helping clients find employment and housing, and obtain medical or other eligible benefits. *"For example, [if] you have a FSP program serving 40 people…you could say, 'This is my partner who is a peer.' It is helpful for someone who has a 40-person case load…[peers could help] find[people] employment to get them out of the system."*

In addition to incorporating peers into existing health care systems, peer providers in programs such as SHARE! or Project Return could partner with other providers to serve these roles. The respites also provide a unique opportunity for guests to gain social support and normalize their experiences. Peer staff can help people build self-sufficiency by linking guests with support groups and to other people to build their social support network. A SHARE! staff person described during the Provider Focus Group Interviews that before their experiences with SHARE!, many guests were completely isolated with no social support, and dependent on the public system of care. As one staff person shared, *"We have a system that trains people how to be a patient. We un-train them."* Staff were able to accomplish this by providing support that is non-judgmental and that lets people know they are not alone. By coming into the respite and participating in support groups, guests see and meet other people facing similar challenges and issues. Guests build connections and are not shamed due to their background or their situation.

Referrals: Both providers developed collaborations with other agencies to support their guests or to enhance their outreach efforts. SHARE! staff reported that they found it beneficial to partner with national recovery organizations, such as Recovery International, and local programs, such as the Center for Collective Wisdom.

Project Return staff established a relationship with the ROADS agency in order to refer guests for linkages to psychiatric, medical, counseling and chemical dependency services. In turn, ROADS refers individuals to Project Return who might benefit from the respite. The program successfully built a mutual and reciprocal relationship of sharing resources for the benefit of the guests. Project Return was also partnered with Mental Health America – Los Angeles, a LACDMH service provider. Staff reported that they received many referrals due to this partnership, which led to more outreach. This may have also helped reduce any traditional service providers' stigma toward the peer program.

SHARE! staff felt significant stigma and discrimination against peer programs by traditional healthcare providers. As one staff person noted, *"It is like we are still 'other'…As long as [LAC]DMH doesn't take proactive steps to counter that, then the norm is not to involve oneself with peers; even the people that want to work with peers are peer pressured to not do so. The fact that we have to work so hard to get people to come to the retreat even though we have such great outcomes. There is stigma attached to our program because our name includes peer. There needs to be action taken to counter this."* Staff highlighted that receiving referrals to the Recovery Retreat from community providers was a great challenge, and they believe that stigma was the main reason.

Peer model supervisors at LACDMH stressed that both providers had very strong skills building trust and rapport with guests, which they saw as an important skill for outreach, engagement, and retention. Peer model supervisors felt that over time, the providers were able to successfully build relationships and reach their target populations. Overall, model supervisors observed great progress with referrals to both programs over the past two years. Even with the challenge of stigma, they noted that both providers have received referrals and built referral relationships. As one model supervisor said, *"Sometimes I think that they struggled with being an equivalent partner to the other providers that were there. But I think that over time they overcame."* Peer model supervisors saw a shift as traditional care providers come to understand the important role and added value of the peer programs over time. They noted that acceptance has improved over the course of this two-year program, but more progress still has to be made over time.

Expectations: SHARE! staff in the Provider Focus Group and participants in the Respite Study both highlighted that people entered the respite with expectations that did not match program intentions, even with an application process. Staff noted that guests are accustomed to receiving mental health or medical services and doing what they are told in a very hierarchical structure. Instead, the respite is "*letting them see how they can live in the real world.*" Some of the people interviewed for the Respite Study highlighted that their expectations differed from the actual respite. Multiple people did not expect the program to be peer-run. Others did not expect the wide range of people living in the respite and the diverse issues they each were facing, or that they would be cooking and cleaning. These differing expectations could indicate an opportunity to adjust outreach efforts to make the purpose,

structure, and activities at the respite more clearly defined for incoming guests. Based on the Respite Study, this did not appear to be an issue for guests at Project Return, possibly because there were fewer structured group activities and house maintenance. However, Project Return staff felt that most guests did not know what to expect from Hacienda of Hope. Most guests told staff that they did not know what to expect because PRRCH is a unique and innovative program.

Peer-Run Integrated Services Management (PRISM)

Project Return Peer Support Network (Project Return)

Project Return's PRISM program–Hope Well–provides participants with peer support, linkages with other community services, and financial support.

- **Peer support:** Peer support varies based on interests, needs and goals set by each participant. In addition to supporting overall wellness, peer support includes tasks such as assisting someone who may just need support going to their doctor's appointment. It can also include re-introducing people to social activities that they may be uncomfortable doing. As one staff person noted, "*Peer support is very broad. There is no diagram of how it works. [It is] sharing your experience and you are trying to empower the person. The most important part of peer support is that you are not trying to do for but you are doing with. Moving towards their goals and not our own as a peer support. Our motto is to meet people where they are but not leave them where they are at.*"
- **Linkages:** In addition to peer support based on the participant's goals and interests, the program facilitates linkages or connections to other services. Linkages are typically focused on housing, education, healthcare, transportation, and social services. As one staff person noted, *"As long as it promotes wellness we try to help."*
- **Financial support:** Financial support to participants can include a security deposit for housing or basic housing supplies such as a piece of furniture. While peer support and linkages are offered to all Hope Well participants, financial support is provided as needed on a case-by-case basis.

Most people involved with Hope Well do not have a support system, such as family or friends. Therefore, staff noted during the Provider Focus Group that they provide that social support as peers. An initial major barrier is building trust with the people. As one staff person noted, *"People are used to being treated less than human due to their mental illness and they find the support of a peer makes them feel that someone cares and that they have a voice. They have to learn what it is like to have someone to support them. Getting that trust is really what they need."* Staff build trust through disclosing that they are a peer, sharing their story, and having regular communication with participants. One staff member also highlighted how they build rapport. *"We also look at their hobbies and what they like to do so that we can build trust with them. It helps when you are trying to calm someone down if someone is on edge. Asking them what makes them happy. We want to make them comfortable."*

Communication: To help build and retain trust and make people feel comfortable, participants are able to work with the staff member they connect with. Peer staff also work together as a team to be support each individual. The staff person works with the participant closely and communicates with them by any method that meets their needs at a specific moment in time. Participants have a set date and time for communication with their contact person, however, staff often have phone communication with participants between formal meetings. The frequency of communication, meetings, and their location also varies by what is happening in the participant's life. For example, one staff person shared, *"One woman I work with is going through child court. She can't read, so my support in helping her read is so important to her."* Staff also focus on communicating a positive or optimistic perspective to help balance the sometimes negative outlook of participants based on their past experiences.

Activities: Staff link people to groups throughout the community based on their goals and interests. Staff believe becoming involved in group activities is important for the participants. However, they believe it can also be accomplished through other activities besides support groups. As one staff person noted, *"It is important to get them to the group atmosphere - the library, the gym. You don't want them to become dependent on you. You need to get them connected to groups or school. I have had that challenge, having people become dependent on me. For me it is important to get them on a schedule, fill their time."*

Outreach and Engagement: Project Return reaches out to potential participants by distributing program flyers, doing presentations for mental health providers (i.e., South Bay Mental Health, Didi Hirsch, Long Beach Mental Health), and through word of mouth from current or past participants. In addition, two staff members are located at Recovery Opportunities and Developing Skills (ROADS) in the community engagement room. At ROADS, Project Return staff share their experiences and a perspective of possibilities and hope. There is no formal referral process with ROADS or other providers. Instead, a casual referral relationship has grown over time.

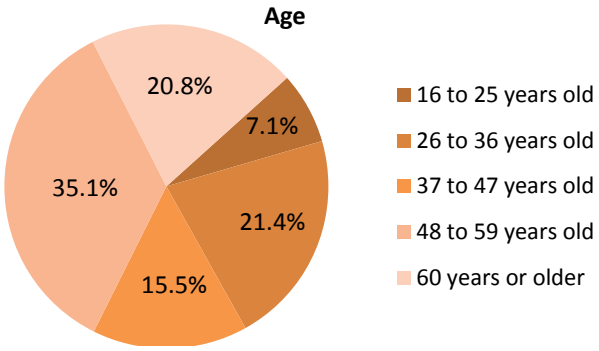
PARTICIPANT CHARACTERISTICS

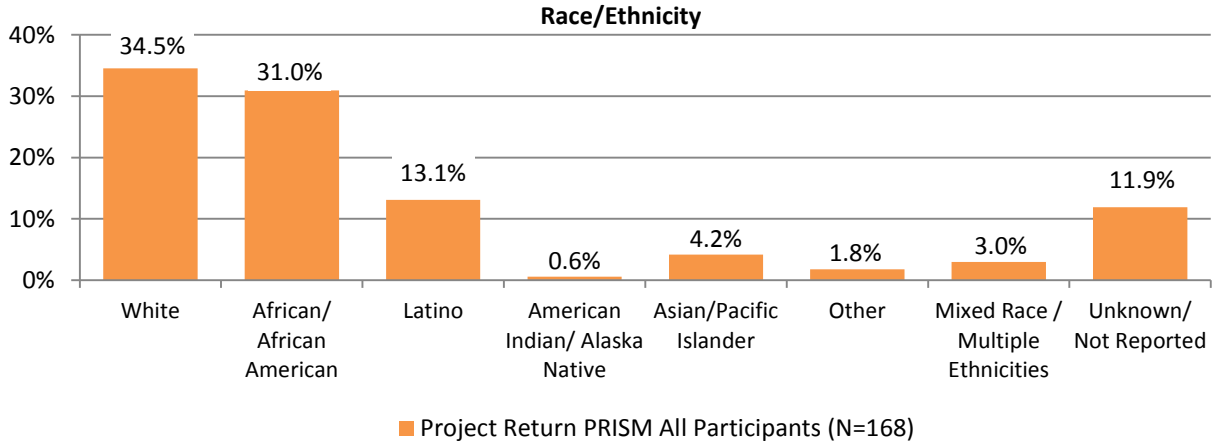
Staff noted that Hope Well participants are typically products of a system of care that has not met their needs and/or has treated them poorly. The people often do not feel heard by other people and providers and feel that others have negative bias against them. As one staff person shared, *"I think the populations we attract are people that feel desperate and feel there is no hope. We open the door and shine the light, provide that hope. We are living proof that it is possible for them to have a better life. When you share that story and [they] see what you have gone through, they see the light. That is hope for them."*

To date, 168 participants have enrolled in Project Return's PRISM program. New participant enrollment peaked in the 1st quarter of 2014 (36.3%).

Most participants at Project Return were adults between the ages of 48 to 59 (35.1%).

Most participants at Project Return identified as White (34.5%) and African/African American (31.0%).





Illness Management and Recovery (IMR): Staff Assessment of Mental Health

Staff are asked to complete the IMR when a participant joins the PRISM program (baseline), and follow-up assessments every three months to assess participants' recovery from the perspective of the peer staff member. The IMR can help staff identify specific areas that they feel may be challenges to the participant, as well as highlight other domains that may be potential strengths that can support their recovery. The IMR has 15 individual items, which, when averaged, make up an Overall score and three subscales: Recovery, Management, and Substance Use. IMR scores range from one to five, and lower scores indicate a participant is doing well in a particular domain or subscale.

Mental Health Status

Project Return PRISM IMR Subscale Scores at Baseline	
Recovery Subscale ***(mean of items 1, 2, 4, 8, & 12)***	**3.00 (N=144)**
Management Subscale ***(mean of items 6, 7, 9, & 11)***	**3.20 (N=144)**
Substance Use Subscale ***(maximum of items 14 & 15)***	**1.47 (N=128)**
Overall IMR Score ***(mean of items 1-15)***	**2.78 (N=144)**

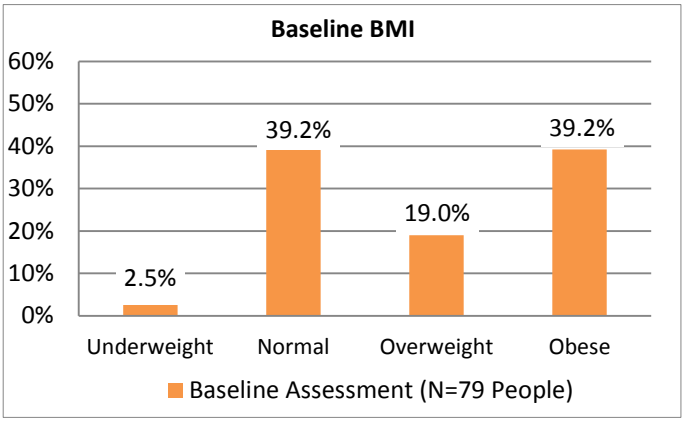
The table to the left shows mean (average) Overall IMR scores and Recovery, Management and Substance Use Subscale scores for all Project Return participants at baseline. Peer staff reported that alcohol and/or drug use was not a factor for 76.6% of participants. The average scores indicate that participants were less impacted by alcohol/drug use or further along in their substance use recovery when they enrolled in the program than with self-management and coping with their mental health and/or wellness.

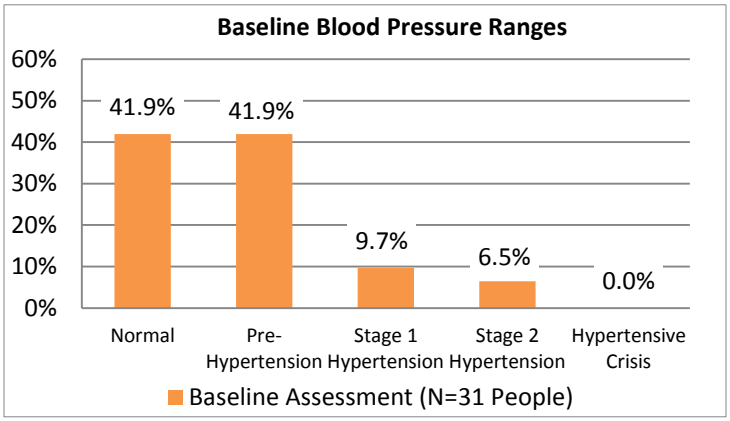
Participant Reported Physical Health Indicators

To get a basic picture of each participant's physical health, participants were encouraged to record their height and weight and measure their systolic and diastolic blood pressure using blood pressure cuffs available at the Project Return PRISM program. Participants' height and weight are used to calculate their Body Mass Index (BMI), a common method of determining whether an individual is at a healthy weight. Categories for BMI were determined using the standards published by the Centers for Disease Control (CDC). Systolic and diastolic readings were combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. These blood pressure categories, used in the table below, only reflect participants' risk for hypertension; additional criteria must be met for a diagnosis of hypertension.

Health Status

In general, most participants had BMIs that were normal (39.2%) or obese (39.2%). The majority of participants had normal or pre-hypertension blood pressure (83.8%).





Past Experiences with Health Care System

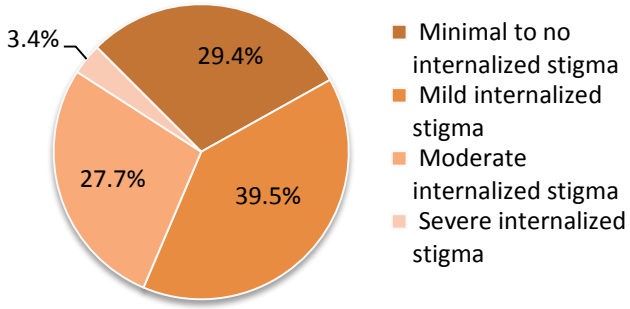
When joining the Project Return PRISM program, most participants (77.2%) reported that they had a regular doctor or healthcare provider that they see for physical health problems. Most participants reported that they had received medical care for a physical health problem less than one month (37.6%) or between one to three months (27.4%) before joining the program. Many participants (56.0%) found it easy to get help for a physical health problem before

joining PRISM, but 36.2% of participants found it to be somewhat or very difficult to get help. The majority of participants (61.7%) reported that they had negative experiences receiving care before joining PRISM.

Internalized Stigma

The Internalized Sigma of Mental Illness Scale (ISMI) assesses participant reported experiences with stigma and common stereotypes about mental illness, as well as the ability to resist or be unaffected by internalized stigma.

Baseline ISMI Scores (N=119 People)



At baseline, participants reported experiencing a range of levels of internalized stigma. While most participants reported experiencing mild or minimal internal stigma before joining PRISM, several participants reported experiencing moderate or severe internalized stigma.

GOALS AND ACTION PLANNING

Staff encourage participants to set meaningful short term and long term goals as part of the program. For example, a short term goal could be getting a driver's license. Staff noted during the Provider Focus Group that housing is the greatest issue for participants, but not necessarily a first priority goal. Some participants are homeless or in transitional housing and are ready for independent living. Others simply do not live in an ideal setting. Through peer support and linkages, Hope Well supports people as they work toward their specific goals.

Staff Reported Linkages and Referrals

Unlike case managers, who generally provide clients with specific referrals or resources, peer staff empower participants to work toward the goals that they establish for themselves and then as requested connect them with resources to help support their work toward their goals. The Linkage Tracker was developed for the peer programs to track participant goals, linkages, and/or assistance support to achieve the goals and the success of each linkage as reported by peer staff. The form was designed to align with the Eight Dimensions of Wellness identified by Substance Abuse Mental Health Services Administration's (SAMHSA). It includes the emotional, physical, environmental, social, occupational, financial, intellectual, and spiritual aspects of a person's life. These Dimensions of Wellness may help people better manage their concerns and experience recovery.

The most common goals expressed by participants and reported on the Linkage Tracker by peer staff at baseline were housing related (26.2%). Many Project Return PRISM participants also described goals to go to school or find a job (20.4%) or were seeking better social support and had goals to improve their relationships, form new friendships and find/attend support groups (19.5%).

At baseline, the majority of participants had goals in one (37.9%) or two (26.7%) Dimensions of Wellness (out of a possible 8) that they wanted to achieve; the remaining 35.4 percent had goals in three or more dimensions. Participants were most likely to have a goal in the Emotional Dimension of Wellness (52.6%). The table below shows the most common linkages peer staff and participants discussed within each Dimension of Wellness, as well as how often staff facilitated each linkage. While this table describes the most commonly made linkages, it is not an inclusive

list of all the linkages that staff may have discussed with participants. Staff may have discussed more than one linkage with a participant. It is important to note that (1) participants may have recovery or life goals in several different Dimensions of Wellness and (2) some participants may not have discussed any goals with staff upon first visiting a program.

The linkages discussed by staff seem to be aligned with the most common goals reported by Project Return PRISM participants. Additionally, staff reported that many of the linkages were successful. A successful linkage can be described as a linkage facilitated by a peer that the participant accomplishes. For example, a peer assists a participant with a housing assistance application while supporting their recovery goal to live independently. If the participant shares with peer staff that they finished the application and submitted it; this would be considered a successful linkage.

Among the most common goals and linkages, 64.7% of linkages with housing resources and support were successful; At least 75% of linkages with emotional wellness self-help and education groups were successful. This indicates that the majority of participants reported attending self-help group sessions when peer staff facilitated the linkage. Many of the linkages were reported as requiring follow-up; however, because peer staff serve as a conduit to support participants as they seek out linkages and resources to achieve their goals, follow-up does not occur in the traditional sense.

Project Return PRISM Linkage Tracker	
Most common linkages discussed with participants based on their goals (N=116)	**How often was linkage made (% People)**
Physical (39.7% of people)	
Linked individual to support group for chronic illness or illness self-management classes	60.9%
Linked to or provided individual medication self-management education or support group (sort pill boxes, getting prescriptions filled)	60.9%
Linked individual to nutrition classes or support groups	54.3%
Linked individual to Community Health Clinic	52.2%
Environmental (40.5% of people)	
Linked individual with resources to assist current independent living environment (Rental Assistance, Utilities Assistance, Legal Assistance)	72.3%
Emotional (52.6% of people)	
Linked or provided individual education or support on emotional wellness	73.8%
Linked individual to self-help group	62.3%
Social (44.0% of people)	
Linked individual to community events or activities based on their interests	62.7%
Linked or provided individual education or support around social skills	58.8%
Occupational (28.4% of people)	
Linked to or provided assistance in searching/applying for jobs	54.5%
Financial (21.6% of people)	
Linked to or provided individual counseling on money management class or group	52.0%
Intellectual (25.9% of people)	
Linked individual with group activity based on hobby or interest	66.7%
Linked to or provided support to explore volunteer opportunities	66.7%
Linked to or provided individual support with enrolling in educational classes/workshops	60.0%
Linked to or provided individual information about continuing education classes in the community	56.7%
Spiritual (12.9% of people)	
Linked to or provided individual referral to non-religious organizations (Yoga, Meditation, etc.)	60.0%
Linked to or provided individual with information about religious organizations	53.3%
Linked to or provided individual with self-help literature	53.3%

IMPACT

Regularly administered outcomes assessments were completed by staff and participants to measure the impact of the program on participants' recovery by assessing changes in mental health, physical health, and substance use/abuse. As the structure of the PRISM program differs from traditional healthcare programs, peer staff also participated in a Provider Focus Group to share the program design and participants' experiences in order to better describe how the program achieved its impact. Staff noted in the Provider Focus Group that Hope Well's impact on

participants is very individualized depending on that person's goals and their needs. Staff think of improvements as *"One step at a time and one person at a time. Focusing on just one person at a time."*

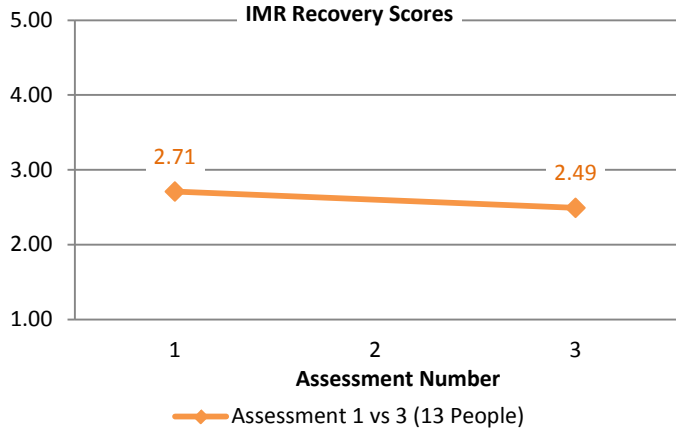
RECOVERY OUTCOMES

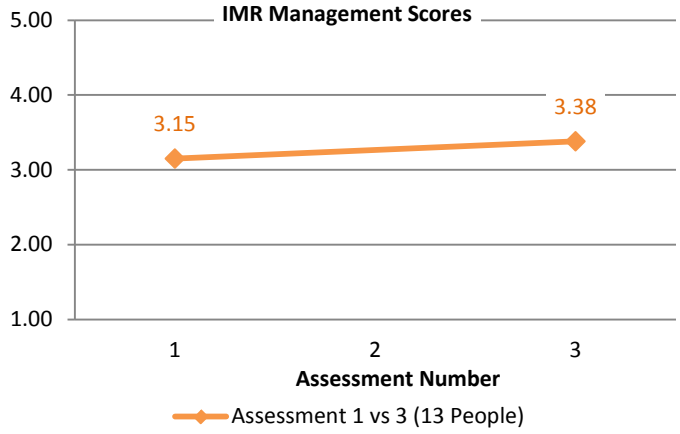
Changes in participants' recovery and mental health outcomes were assessed using; (1) the IMR Recovery and Management subscales, (2) the Mental Health subscale from the participant reported PROMIS Global Health Scale, and (3) the Strengths subscale from the CHOIS. Additionally, specific items from the measures were analyzed to examine improvements in specific areas of interest for the peer programs, such as coping skills and social support. Improvement in participants' mental health and recovery were assessed using statistical significance analyses and by evaluating the percentage of participants with applied meaningful improvements on the subscales. Applied meaningfulness is determined using the Minimal Important Difference (MID), which represents the smallest improvement in a scale score that would indicate an observable change in participant health (More detailed information about how MID are calculated can be found here). If the difference between a participant's baseline and six-month follow-up scores on a specific outcome measure is greater than the MID, that participant is considered to have achieved an applied meaningful change for that outcome.

For the CHOIS Strengths subscale, a program is considered to have a positive outcome if participants improve on the CHOIS, or if they maintain a "positive" score during the evaluation period. Many participants were considered "positive" at the baseline assessment, meaning their score indicated that they had many strengths that they could utilize during their recovery process.

Illness Management and Recovery (IMR) Scale: Staff Assessment of Mental Health

Across Project Return PRISM participants with matched assessments (N=13), 38.5% of participants had an applied meaningful improvement from baseline to six months on the Recovery subscale and 15.4% of participants had an applied meaningful improvement from baseline to six months on the Management subscale. This suggests that some participants with matched assessments made progress towards their recovery, and improved their ability to manage their mental health six months after enrolling in the program. However, there were no statistically significant changes in mean Recovery and Management subscale scores from baseline to six months.





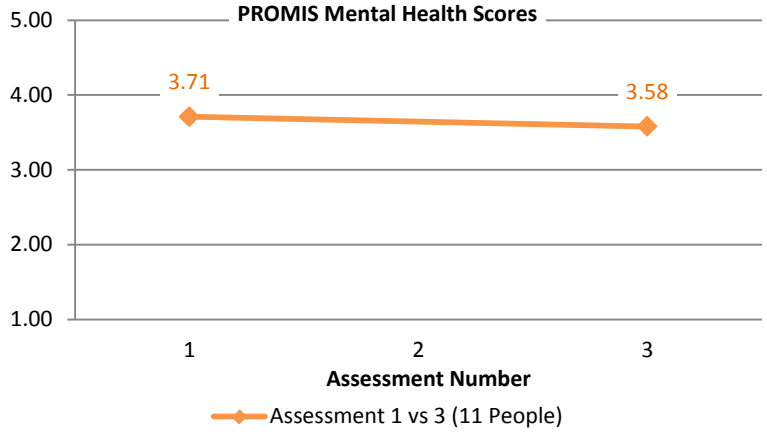
Project Return PRISM participants experienced a statistically significant improvement in "time in structured roles" six months after joining the program. From baseline to six months, participants with matched assessments spent significantly more time working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment. While not a statistically significant change, participants also engaged in more self-help activities and had more contact with people outside of their family six months after enrollment compared to baseline. Staff reported that participants also had more knowledge about symptoms, treatment, coping strategies (coping methods), and better medication adherence six months after enrollment compared to baseline.

Participant Completed Patient Reported Outcomes Measurement Information System (PROMIS)

The PROMIS Global Health Scale is a 10-item measure aimed at assessing participant reported health including: physical health, pain, fatigue, mental health, and social health. Items are used to create a Total Global Health score and two subscale scores, Physical Health and Mental Health. PROMIS Global Health scores range from 1 to 5; however, participants are also asked to rate their pain using a scale from 0 (no pain) – 10 (worst imaginable pain), which is then categorized into a 5-point scale. For all PROMIS items and scales, lower scores represent fewer health concerns (i.e. lower scores are desirable).

PROMIS Global Health - Mental Health Subscale

Across Project Return PRISM participants with matched assessments (N=11), many participants had an applied meaningful improvement in PROMIS Mental Health subscale scores from baseline to six months (45.5%). This suggests that participants may have experienced improvements in mental health after enrolling in the program. While not statistically significant, mean PROMIS Mental Health subscale scores also decreased for participants with matched assessments.

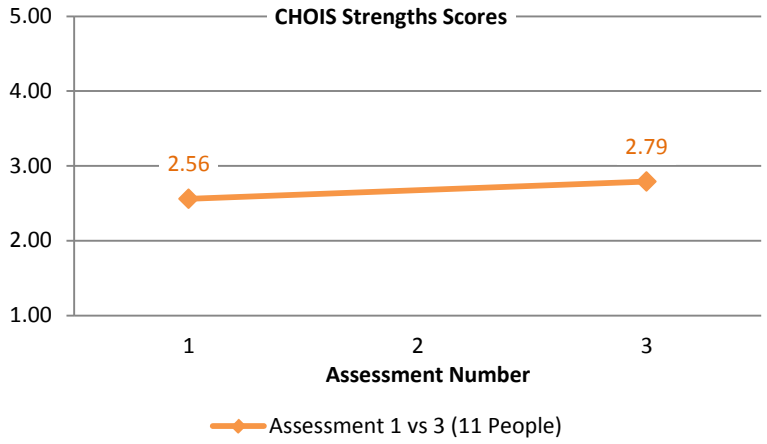


"I was working with this individual in [gender] transition. He had an issue at home where his parents were trying to promote religion as a cure. They had a falling out. I got a text message from him saying he is suicidal and sent me an address. I went to the address. He had the means to commit suicide. He wasn't attempting, but on my way there I called the PET team [Psychiatric Emergency Team]. I was able to calm him down. He said if you call me by my transitional name he would stop. He threw the knife in the street. I calmed him down until the PET team got there. He has come a long way since then. He felt that support enough for him to reach out to me." – Project Return staff person

Participant Completed Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS)

The CHOIS Supplement is a participant-rated recovery-based measure that assesses several mental health related domains, including suicidal ideation, anxiety, trauma, and psychosis (i.e. hearing voices). It also includes several items which assess recovery-oriented personal strengths, such as having goals and working towards achieving them, feeling good about oneself and living in a home that feels safe. These Strengths can assist participants in their recovery. All CHOIS items and subscales range from 1 to 5, with lower scores being desirable.

Across participants with matched assessments (N=11), 27.3% of participants had an applied meaningful improvement in their Strengths subscale scores six months after enrollment in PRISM compared to baseline. While most CHOIS Strengths item scores increased (non-significantly)



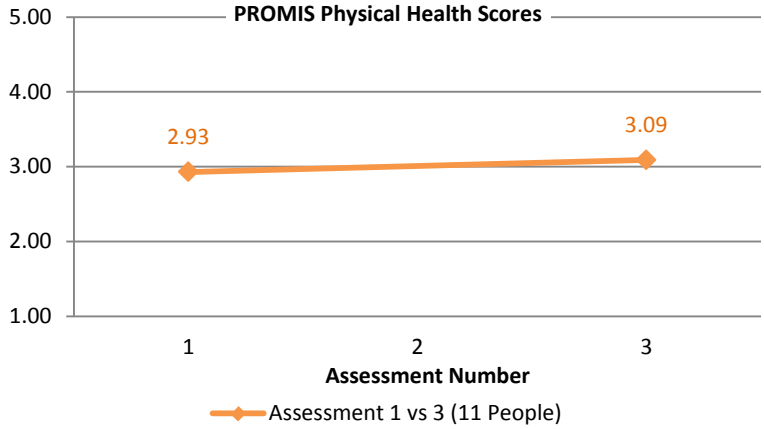
from baseline to six months, participants reported feeling more spiritually connected six months after enrollment. This is a positive impact, as many participants expressed a goal of being more spiritually connected on the Linkage Tracker.

PHYSICAL HEALTH OUTCOMES

Changes in participants' physical health were assessed using the Physical Health subscale of the PROMIS Global Health scale.

PROMIS Global Health – Physical Health Subscale

Across participants with matched assessments (N=11), applied meaningful improvement in physical health was seen for 18.2% of participants from baseline to six months. While not statistically significant, participants reported experiencing less pain, on average, six months after enrollment compared to baseline. There were no significant changes in PROMIS Physical Health subscale scores from the baseline to the six-month assessment for participants with matched assessments.



During the Provider Focus Group, staff shared an example of one participant who was homeless when she came to PRISM but now has a Section 8 voucher. Before the program, she had never been to the doctor. Now she sees her doctor and works out regularly.

SUBSTANCE USE OUTCOMES

Changes in participants' substance use were assessed using the PROMIS-Derived Substance Use Scale, which assesses the participant's perception of the negative consequences of their substance use. Additionally, all participants were asked how frequently they used alcohol or illegal substances. Improvement was also tracked using the IMR Substance Use Subscale, which asks staff to rate how much alcohol and drugs affect their participant. Improvement in substance use was assessed by using statistical significance analyses and evaluating the percentage of participants who maintained "positive" ratings or made applied meaningful improvements on the PROMIS-Derived Substance Use Scale, and the IMR Substance Use Subscale. Participants were also considered to have achieved a positive outcome for substance use if they maintained no alcohol or substance use, or reduced their use over the evaluation period.

Participant Reported Substance Use Items

Participants reported how frequently they used alcohol and illicit drugs on the Physical Health and Behaviors Survey. At baseline, most participants reported that they had not used an illegal drug (75.2%) or consumed alcohol (60.3%) in the past six months.

In the past 6 months…	Never	Less than once a week	1-3 times per week	4 or more times per week	Every day
How often did you have any kind of drink containing alcohol, such as beer, wine, or liquor?					
Baseline Assessment (N=116 People)	60.3%	25.9%	7.8%	2.6%	3.4%
How often did you use an illegal drug or use a prescription medication for nonmedical reasons?					

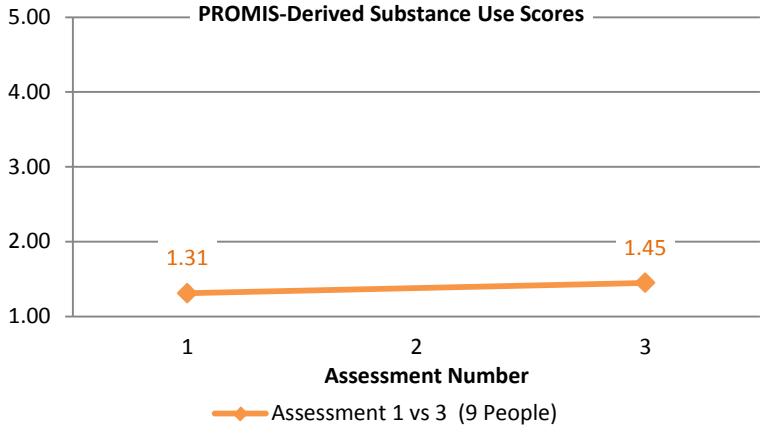
Baseline Assessment (N=117 People)	75.2%	9.4%	9.4%	1.7%	4.3%

From the baseline to the six month assessment, most participants with matched assessments (N=10) maintained no alcohol use (80.0%). Similarly, many participants with matched assessments (N=11) maintained no illegal drug use six months after enrollment (72.7%). However, there were no statistically significant reductions in alcohol consumption or illicit drug use among Project Return PRISM participants with matched assessments during the same time period.

Participant Reported Substance Use: PROMIS-Derived Substance Use

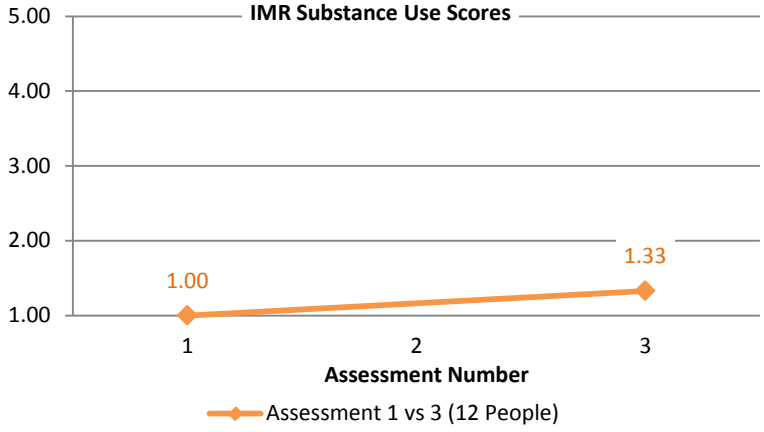
The 12-item PROMIS-Derived Substance Use measure assesses participants' perception of negative consequences of their alcohol and/or other substance use. Item and total scale scores range from 1 to 5, with lower scores being positive as they indicate fewer perceived consequences associated with alcohol and/or other substance use.

For Project Return PRISM participants with matched assessments (N=9), from baseline to six months, 77.8% maintained no or relatively few perceived negative consequences from substance use and 11.1% of Project Return PRISM participants had an applied meaningful reduction in negative consequences associated with alcohol and/or drug use. However, there was a non-significant increase in mean PROMIS-Derived Substance Use ratings from the baseline to the six-month assessment for participants with matched assessments.



Staff Reported Substance Use: IMR Substance Use Subscale

Project Return PRISM participants with matched assessments (N=12) had a non-significant increase in IMR Substance Use scores from baseline to six months. However, IMR Substance scores were relatively low, suggesting that staff perceived drugs and alcohol to be less likely to impact the lives of participants. From baseline to six months, no participants had an applied meaningful reduction in substance use scores.



QUALITY OF LIFE OUTCOMES

While there are many indicators of participant quality of life, the current evaluation focused on incarcerations, participant reports of emergency service use and hospitalization, constructive activities such as employment, volunteer work, enrollment in school, housing, housing retention, and mental health stigma. To determine participant improvement, statistically significant changes in quality of life outcomes were assessed. Improvement was also assessed by examining the proportion of participants who maintained "positive" ratings or made applied meaningful improvements on the quality of life outcomes. Examples of participants with "positive" assessments included those with: no emergency service use, no incarcerations, or who maintained current employment.

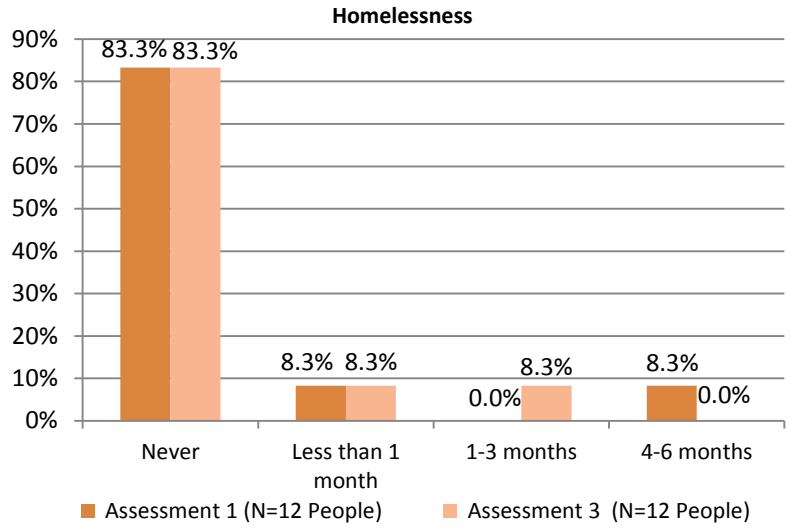
During the Provider Focus Group, staff shared multiple examples of the emotional support they provided to participants and the impact that support had on participants. One example staff noted was a person who needed to go into the hospital but was very anxious about going. The staff encouraged her to imagine that everyone at the hospital was her friend. This helped calm her down before she got to the hospital and made the transition to hospitalization less stressful and traumatic. Now that she is out of the hospital the program is working with her to find housing in her desired neighborhood.

Homelessness

Staff report each participant's experience with homelessness as part of the Staff Assessment.

At the baseline assessment, many Project Return PRISM participants (30.2%) were homeless during the prior six months. Additionally, 7.8% of participants experienced chronic homelessness (defined as being homeless for at least four of the previous six months) before enrolling in Project Return PRISM.

The majority of Project Return PRISM participants with matched assessments (N=12) maintained housing between baseline and the six month assessment (83.3%). While not statistically significant, there was a reduction in the average number of days spent homeless among participants who reported homelessness at both baseline (Assessment 1) and six-month follow-up assessment (Assessment 3). Specifically, participants were homeless for an average of 15 days at baseline and 9 days at the six-month follow-up assessment. No Project Return participants with matched assessments experienced chronic homelessness six months after enrolling in the program.



Incarcerations

Participants reported how often they were incarcerated on the Physical Health and Behaviors Survey. At baseline, the majority of participants reported that they had not been incarcerated in the past six months (94.0%).

During the past 6 months, how many times were you sent to jail or prison?					
	None	1-3 times	4-6 times	7-10 times	More than 10 times
Baseline Assessment (N=116 People)	94.0%	6.0%	0.0%	0.0%	0.0%

All participants with matched assessments (N=11) maintained no incarcerations from baseline to six months (100.0%).

Emergency Services and Hospitalizations

Participants reported how often they used emergency or hospital services on the Physical Health and Behaviors Survey. At baseline, half of participants (53.9%)reported that they had not been to an emergency room and 65.0% reported that they had not been hospitalized during the past six months.

In the past 6 months…	None	1-3 times	4-6 times	7-10 times	More than 10 times
How many times did you go to an emergency room?					
Baseline Assessment (N=115 People)	53.9%	38.3%	4.3%	1.7%	1.7%
How many times were you admitted to a hospital?					
Baseline Assessment (N=117 People)	65.0%	31.6%	2.6%	0.9%	0.0%

For participants with matched assessments from baseline to six months (N=11), 27.3% reduced the number of emergency room visits and 10.0% reduced the number of hospital visits. During the same time periods, 45.5% and 50.0% maintained no ER or hospital visits, respectively. However, there were no statistically significant changes in emergency room or hospital use from baseline to six months for PRISM participants with matched assessments.

Constructive Activities

On the Physical Health and Behaviors Survey, participants were asked to indicate if they had engaged in paid employment, participated in volunteer activities, or attended school in the previous six months. More Project Return PRISM participants reported engaging in volunteer activities at the baseline assessment than engaging in paid employment or attending school. From baseline to six months, 9.1% of participants with matched assessments (N=11) started a new volunteer activity and 18.2% continued a volunteer activity or paid employment. Ten percent of participants with matched assessments (N=10) continued to attend school from baseline to six-month assessment. There were no statistically significant changes in engagement in these activities from baseline to six months.

During the past 6 months, which of the following have you done?	
	% Engaged
Have paid employment?	
Baseline Assessment (N=117 People)	19.7%
Participate in volunteer activities?	
Baseline Assessment (N=117 People)	36.8%
Attend school?	
Baseline Assessment (N=116 People)	12.9%

SATISFACTION

The participant-completed Feedback Survey was administered to learn more about participants' experiences with the PRISM program, and to help staff make ongoing quality improvements to the program to ensure that participants benefit from the support and recovery environment. In general, satisfaction with the Project Return PRISM program was high. All of the participants who completed the Feedback Survey six months after enrollment (N=12) agreed that there are people available to talk with them as often as they felt was necessary, and that they participated in decision making about recovery and wellness. The majority of participants who completed the Feedback Survey agreed that their cultural background and beliefs about wellbeing and health were respected by the program (91.7%). Most participants agreed that their mental health, physical health, and substance use concerns were addressed by PRISM (91.7%). Additionally, all participants who completed the survey agreed that they felt comfortable talking with peer staff about personal matters.

However, participants were less likely to agree with certain items on the Feedback Survey. Participants were least likely to endorse the item: "Participating in this program has made me more effective in my relationships (50.0%)." This relatively low rating could be due to several factors. It could take more than six months for relationships to improve, or participants could be chasing a moving target. As they learn more about their relationships, they may begin to have higher expectations for themselves and feel like they are less effective.

Peer staff wanted to assess participants' feelings of self-efficacy. Two items were developed by the evaluation team with the peer staff to assess this domain. Project Return PRISM participants were asked about their self-esteem and sense of control on the Feedback questionnaire. Six months after joining PRISM, participants who completed the

survey reported that they had a low level of self-esteem (41.6%) but many participants reported having average or high level (58.3%) of self-esteem. Most participants reported feeling either some control (41.7%) or a high level of control (ratings between seven and 10, on a scale of zero to 10) six months after enrollment in PRISM (25.0%).

Project Return PRISM Guest Feedback Survey			
	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
I like coming to this program.			
Six Month Assessment (N=12 People)	0.0%	33.3%	66.7%
If I had other choices, I would still come to this program.			
Baseline Assessment (N=12 People)	8.3%	25.0%	66.7%
People were available to talk with me as often as I felt it was necessary.			
Six Month Assessment (N=12 People)	0.0%	0.0%	100.0%
I feel safe when I am at this program.			
Six Month Assessment (N=12 People)	0.0%	22.2%	77.8%
As a result of this program I feel empowered to make positive changes in my life.			
Six Month Assessment (N=12 People)	0.0%	8.3%	91.7%
This program helps me reach my goals.			
Six Month Assessment (N=12 People)	0.0%	25.0%	75.0%
This program respects my cultural needs (race, religion, language, etc.).			
Six Month Assessment (N=12 People)	0.0%	8.3%	91.7%
My mental health, physical health, and substance use concerns are addressed.			
Six Month Assessment (N=12 People)	0.0%	8.3%	91.7%
My beliefs about health and well-being were respected in this program.			
Six Month Assessment (N=12 People)	0.0%	8.3%	91.7%
I have found referrals to resources that assisted me and/or my family.			
Six Month Assessment (N=12 People)	0.0%	9.1%	90.9%
I participated in the decision making about my recovery and wellness.			
Six Month Assessment (N=12 People)	0.0%	0.0%	100.0%
As a result of this program, I deal more effectively with daily problems.			
Six Month Assessment (N=12 People)	0.0%	41.7%	58.3%
Participating in this program has made me more effective in my relationships with family and friends.			
Six Month Assessment (N=12 People)	8.3%	41.7%	50.0%
After coming to this program, I am better able to work towards my life goals.			
Six Month Assessment (N=12 People)	0.0%	33.3%	66.7%
I feel comfortable talking about personal matters with peer staff.			
Six Month Assessment (N=12 People)	0.0%	0.0%	100.0%
I participate in activities with others in the community of my choice.			
Six Month Assessment (N=12 People)	8.3%	25.0%	66.7%

Please rate your current level of self-esteem using the scale below. (Six Month Assessment=12 People)										
Very low	1	2	3	4	Average	6	7	8	9	High
0.0%	0.0%	8.3%	25.0%	8.3%	16.7%	16.7%	8.3%	8.3%	0.0%	8.3%

Please rate how much control you have over your life using the scale below. (Six Month Assessment=12 People)										
No control	1	2	3	4	Some control	6	7	8	9	Complete control
0.0%	0.0%	0.0%	0.0%	16.7%	41.7%	16.7%	25.0%	0.0%	0.0%	0.0%

SHARE!

SHARE!'s PRISM program provides social support and connections to needed services that someone cannot typically get from a social worker or case manager. SHARE! staff noted that the program empowers participants to take charge of their lives, create and strengthen their social networks, identify and pursue their goals, and learn that they have all the resources they need to handle life's challenges. SHARE! offers this program at both their Downtown Los Angeles and their Culver City locations.

- **Social support:** SHARE! staff build relationships with participants. Staff noted that they are often their only social support. *"…When you don't have social support, you have more mental health problems, more physical health problems. So we became family for them. We become the NAMI…rather than pushing a case manager to [get them housing], we do it ourselves."* Other specific examples of social support include organizing birthday parties and holiday potlucks and maintaining regular contact via phone or in-person.
- **Linkages:** In addition to peer support and based on the person's goals and interests, the program facilitates linkages or connections. Linkages are typically focused on housing or self-help support group connections. Peer staff also assist participants with obtaining eligible benefits such as social security or medical benefits.
- **Financial support:** Financial support to participants can include acute needs such as storage bills or rental assistance. SHARE! Collaborative Housing does not charge security deposits or require basic supplies. However, SHARE!'s strategy is to support people in finding the resources they need to meet their own needs (such as doing odd jobs to make up a rent shortfall); thus discouraging dependency.

Communication: Staff communicate with participants on a regular basis. However, there are no set appointments. Participants are not assigned to one staff person but instead get to know and work with multiple staff. As one staff person shared, *"All of us will have some contact with them throughout the week. Sometimes I am not around the office when they come in and if I am not around I won't be able to interact with them. We have a huge in and out flow. About 150 people come through the doors each day. By having all staff knowing who is who… it is helping us talk to participants and get the untold story of what is going on and their goals. Because sometimes they may have a connection with me in certain things and they may have a connection with someone else in other things."*

One staff person described the typical communication with participants: *"It is checking in during the week and asking 'How did it go this week?' Then being able to follow up. 'Ok, what is coming next?' Helping them figure out what support they need and what support they think they need. Sometimes people come in and they think that they need us to do this for them but giving them the support to work with someone and get started and they are like 'it is okay, I got it.' And they come back and they are like 'I went to Target and I filled out an application.' "* The support that staff provide is conversational and casual; it is not at a regular time each week. If someone goes to prison or is hospitalized, the program maintains contact with them by visiting if possible or writing letters. Staff have weekly team meetings to discuss challenges and how to best provide support and linkages to each person.

Activities: SHARE! staff noted that their focus is on nurturing relationships and creating a supportive environment so that self-help support groups and people with recovery are available and accessible to those who may lack role models and social connections. SHARE! staff are trained to encourage people to attend self-help support groups to cope with a variety of life's challenges, as well as to meet more people. Most participants attend support groups. As one staff person shared, *"Our goal is to giving them friends and a paid friend is not a friend. So we put them into self-help groups."* Participants choose from a spectrum of different self-help support groups including mental health groups (i.e., Recovery International, Emotions Anonymous), relationship groups (i.e., Co-Dependents Anonymous, Sex and Love Addicts Anonymous), addiction groups (i.e., Alcoholics Anonymous, SMART Recovery), family groups (i.e., NAMI, Nar-Anon) , or medical groups (i.e., for HIV+, breast cancer), and more.

Additionally, participants are encouraged to volunteer at SHARE! and implement group activities based on their own interests. SHARE! PRISM participants are an integral part of running SHARE! Downtown or SHARE! Culver City. PRISM

volunteers do everything from maintenance and outreach to attending community meetings to taking service positions in the self-help groups. They plan and prepare special events such as holiday celebrations, health fairs, birthday parties, sobriety anniversaries, dances, marathon meetings, and the Festival of Recovery. Volunteers support other people another around immediate needs, such as how to fill out General Relief paperwork, get into a shelter, find housing, moving, writing a resume, how to get a driver's license or birth certificate, and accompanying one another to job interviews.

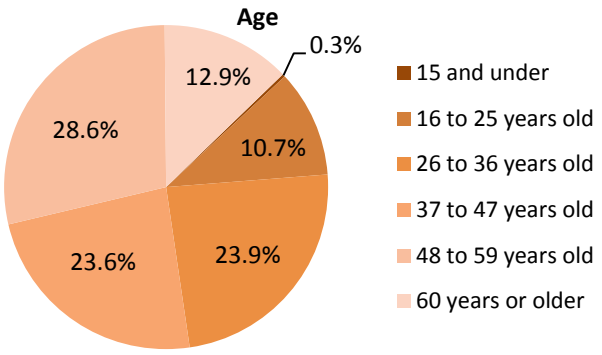
Outreach and Engagement: SHARE! posts flyers about the program and ensures that the program is highlighted in their support group meetings. Staff shared that they also send their outreach team into the community where they give presentations about the program to mental health providers and other community organizations. The program also seeks referrals from community providers.

PARTICIPANT CHARACTERISTICS

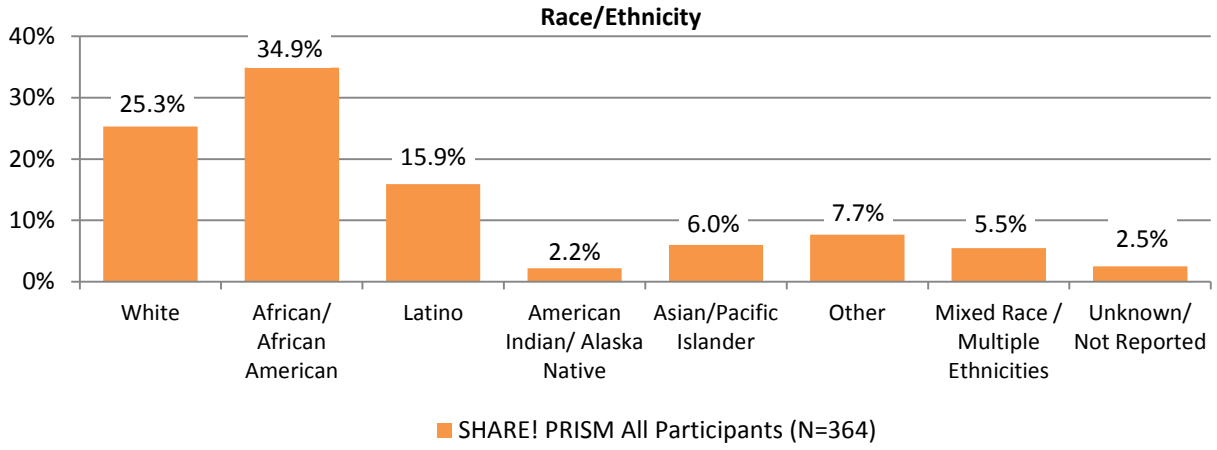
Program participants can be anyone with a mental health concern. Staff highlighted that PRISM participants are often people already involved with SHARE! self-help support groups. As one staff person shared, *"We have a couple of people that are in some type of hospital/nursing care facility and what we are able to do is to take volunteers to spend time with them, read to them, just participate and interact with them…We bring cards signed by everyone. We do collages of pictures for them. We do what the family will normally be doing but there is no family…We did not know that is one of the things that we were going to do when we started PRISM but it is one of the things that we discovered."* Staff noted that the participants vary slightly for each SHARE! location with the Downtown Los Angeles location serving more homeless people living in Skid Row than the Culver City location. In addition, staff highlighted that most participants are not college educated.

To date, 364 participants have enrolled in SHARE!'s PRISM program. New participant enrollment peaked in the 1st (35.7%) and 2nd (21.4%) quarters of 2014.

Most participants at SHARE! were adults between the ages of 26 and 59 (76.1%). A very small percentage of participants (0.3%) were 15 years old or younger.



Most of the participants at SHARE! identified as African/African American (34.9%) and White (25.3%).



Illness Management and Recovery (IMR): Staff Assessment of Mental Health

Staff are asked to complete the IMR when a participant joins the PRISM program (baseline), and at follow-up assessments every three months to assesses participants' recovery from the perspective of the peer staff member. The IMR can help staff identify specific areas that they feel may be challenges to the participant, as well as highlight other domains that may be potential strengths that can support the participant's recovery. The IMR has 15 individual items, which, when averaged, make up an Overall score and three subscales: Recovery, Management, and Substance Use. IMR scores range from one to five, and lower scores indicate a participant is doing well in a particular domain or subscale.

SHARE! PRISM IMR Subscale Scores at Baseline	
Recovery Subscale ***(mean of items 1, 2, 4, 8, & 12)***	**3.21 (N=278)**
Management Subscale ***(mean of items 6, 7, 9, & 11)***	**3.30 (N=276)**
Substance Use Subscale ***(maximum of items 14 & 15)***	**2.20 (N=261)**
Overall IMR Score ***(mean of items 1-15)***	**2.98 (N=277)**

Mental Health Status

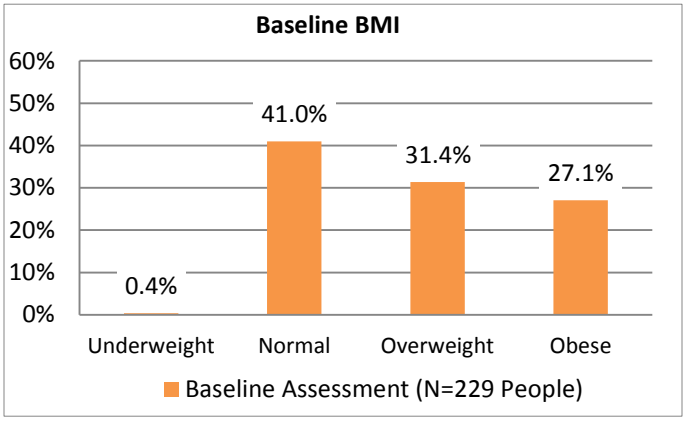
The table to the left shows mean (average) Overall IMR scores and Recovery, Management and Substance Use Subscale scores for all SHARE! PRISM participants at baseline. The average scores indicate that SHARE! participants were experiencing more difficulty with self-management when they enrolled in the PRISM program than with coping with their mental health and/or wellness and substance use.

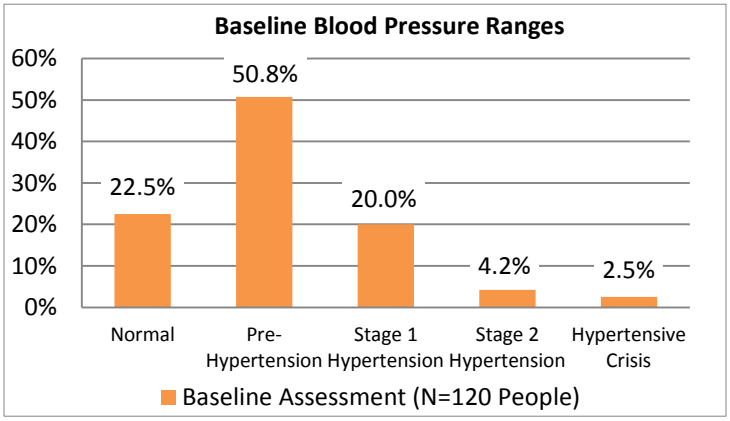
Participant Completed Physical Health Indicators

To get a basic picture of each participant's physical health, participants were encouraged to record their height and weight and measure their systolic and diastolic blood pressure using blood pressure cuffs available at the SHARE! PRISM program. Participants' height and weight are used to calculate their Body Mass Index (BMI), a common method of determining whether an individual is at a healthy weight. Categories for BMI were determined using the standards published by the Centers for Disease Control (CDC). Systolic and diastolic readings were combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. These blood pressure categories, used in the table below, only reflect participants' risk for hypertension; additional criteria must be met for a diagnosis of hypertension.

Health Status

In general, most SHARE! PRISM participants had BMIs that were normal (41.0%), but the majority of participants were overweight or obese (58.5%). Half of participants had pre-hypertension blood pressure (50.8%).





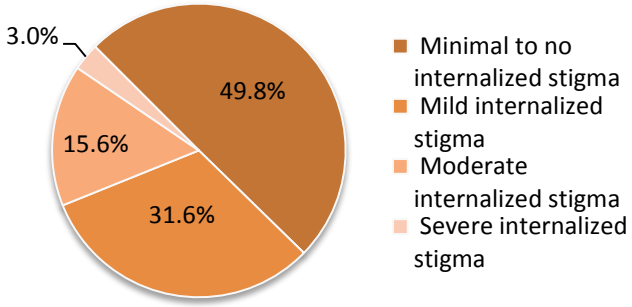
Past Experiences with Health Care System

When joining the SHARE! PRISM program, most participants (65.7%) reported that they had a regular doctor or healthcare provider that they saw for physical health problems. Many participants reported that they had received medical care for a physical health problem less than 1 month (23.5%) or between 1-3 months (25.6%) before joining the program. Most participants (64.2%) found it easy to get help for a physical health problem before joining the program, but 27.1% of participants found it to be somewhat or very difficult to get help. Some participants (33.2%) reported that they had negative experiences receiving care before joining the program.

Internalized Stigma

The Internalized Sigma of Mental Illness Scale (ISMI) assesses participant reported experiences with stigma and common stereotypes about mental illness, as well as the ability to resist or be unaffected by internalized stigma.

Baseline ISMI Scores (N=231 People)



At baseline, SHARE! PRISM participants reported experiencing a range of levels of internalized stigma. While most participants reported experiencing mild or minimal internal stigma before joining PRISM, some participants reported experiencing moderate or severe internalized stigma.

GOALS AND ACTION PLANNING

The SHARE! program is tailored to the individual goals of each person. When beginning the program, people are asked to develop a five year success plan. This plan is intended to encourage them to dream about what their life could look like in that time and what they would consider success. Staff and the participant then talk about short term and long term goals. Staff work with participants to achieve their personal goals, including developing computer skills, working on their resume, or applying for school.

Staff noted in the Provider Focus Group that housing is a common goal across the program at both SHARE! locations. In SHARE! Downtown Los Angeles, people want to get out of Skid Row or get out of a shelter and move to single room occupancy housing. One of the reasons staff cited for participants wanting to leave Skid Row was so that they can obtain or maintain their sobriety. Staff shared that some participants' initial ultimate dream is to get a Section 8 voucher because they feel that is all they can accomplish. Obtaining benefits or employment was another goal described by PRISM staff. Some people also feel that they cannot work because they have not been able to hold down a job in the past, so they strive to get Social Security benefits (SSI/SSDI). In contrast, some people that already have SSI/SSDI want to get a job but are fearful that if they get a job, their benefits will go away. Although the Culver City site has fewer homeless participants, many still had goals to improve their housing as well as education and job goals. At both locations, people told staff that they are interested in reconnecting with their families.

Staff Reported Linkages and Referrals

Unlike case managers, who generally provide clients with specific referrals or resources, peer staff empower participants to work toward the goals that they establish for themselves and then as requested connect them with

resources to help support their work toward their goals. The Linkage Tracker was developed for the peer programs to track participant goals, linkages, and/or assistance support to achieve their goals, and the success of each linkage as reported by peer staff. The form was designed to align with the Eight Dimensions of Wellness identified by Substance Abuse Mental Health Services Administration's (SAMHSA). It includes the emotional, physical, environmental, social, occupational, financial, intellectual, and spiritual aspects of a person's life. These Dimensions of Wellness may help people better manage their concerns and experience recovery.

As reported by peer staff on the Linkage Tracker, many participants expressed having housing goals at baseline (15.2%). Many SHARE! PRISM participants also described goals to go to school or find a job (17.6%) and/or improve their mental health and wellness (19.5%). However, 33.5% of participants did not have any set goals at baseline, or had not shared their goals with staff. There are several possible reasons for this high percentage at baseline. For some participants, it may take time after enrolling in SHARE! to explore the program and determine what they want to accomplish and develop specific goals. Additionally, it can take time to build trust and establish a connection with some participants. In some cases, especially for those in which the Linkage Tracker is completed soon after the participant enters the program, staff may still be building relationships and the participants may not have shared their goals. Peer staff shared that if a participant is in crisis when they come to SHARE!, they may not be able to think beyond surviving on a particular day. They do not set goals because they do not believe they will be able to do anything other than survive.

At baseline, the majority of SHARE! PRISM participants had goals in one Dimension of Wellness (55.1%) (out of a possible 8) that they wanted to achieve; the remaining 44.9 percent had goals in two or more dimensions. The linkages discussed by staff during the Provider Focus Groups seem to be aligned with the most common goals of SHARE! PRISM participants. Participants were most likely to have a goal in the Emotional (41.5%) Dimension of Wellness. The table below shows the most common linkages peer staff and participants discussed within each Dimension of Wellness, as well as how often staff facilitated each linkage. While this table describes the most commonly made linkages, it is not an inclusive list of all the linkages that staff may have discussed with participants. Staff may have discussed more than one linkage with a participant. It is important to note that (1) participants may have recovery or life goals in several different Dimensions of Wellness and (2) some participants may not have discussed any goals with staff upon first visiting a program.

Peer staff reported that many of the linkages were successful. A successful linkage can be described as a linkage facilitated by a peer that the participant accomplishes. For example, a peer assists a participant with a housing assistance application while supporting their recovery goal to live independently. If the participant shares with peer staff that they finished the application and submitted it; this would be considered a successful linkage.

Among the most common goals and linkages, 64.0% of linkages with PRRCH and 78.6% of linkages with transitional housing resources were successful. A small percentage of linkages with housing resources were reported as requiring follow-up; however, because peer staff serve as a conduit to support participants as they seek out linkages and resources to achieve their goals, follow-up does not occur in the traditional sense. Between 80-90% of linkages with emotional wellness self-help and education groups were successful, and more than 88% of linkages involving job skills training or support were successful. This indicates that the majority of participants attended self-help group sessions and utilizing support with job seeking when peer staff facilitated the linkage.

SHARE! PRISM Linkage Tracker	
Most common linkages discussed with participants based on their goals (N=272)	**How often was linkage made (% People)**
Physical (27.9% of people)	
Linked individual to substance abuse recovery self-help group	71.1%
Environmental (35.3% of people)	
Linked individual to Peer Run Respite Care Home (PRRCH)	53.1%
Linked individual with transitional living program	44.8%
Emotional (41.5% of people)	
Linked individual to emotional self-help group	99.1%
Linked or provided individual education or support on emotional wellness	46.0%
Social (38.2% of people)	
Linked individual to social skills self-help group (Conflict resolution, Communication)	86.5%
Linked individual to community events or activities based on their interests	52.9%
Occupational (33.1% of people)	
Linked to or provided assistance in searching/applying for jobs	66.7%
Linked to or provided individual with workplace skills class or support group	64.4%
Linked to or provided individual with training in searching/applying for jobs	58.9%
Linked individual to assistance editing/creating a resume or cover letter	57.8%
Financial (24.6% of people)	
Linked to or provided individual counseling on money management class or group	59.7%
Intellectual (17.3% of people)	
Linked to or provided support to explore volunteer opportunities	95.7%
Spiritual (21.0% of people)	
Linked to or provided individual with self-help literature	91.2%

IMPACT

Regularly administered outcomes assessments were completed by staff and participants to measure the impact of the program on participants' recovery by assessing changes in mental health, physical health and substance abuse.

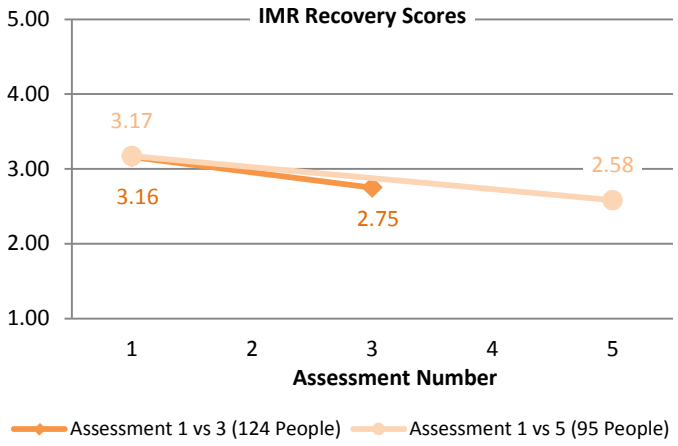
RECOVERY OUTCOMES

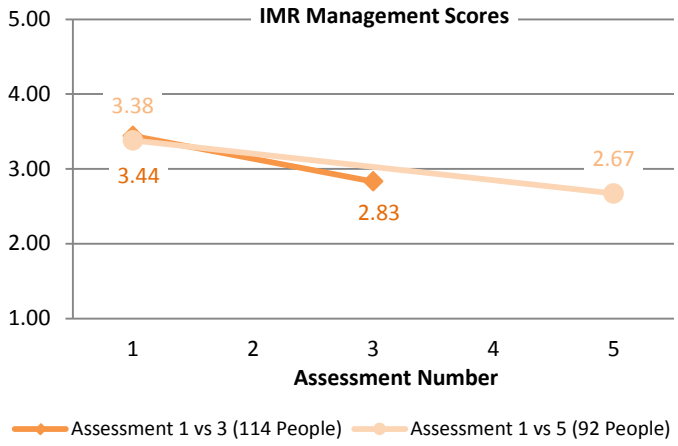
Changes in participants' recovery and mental health outcomes were assessed using; (1) the IMR Recovery and Management subscales, (2) the Mental Health subscale from the participant reported PROMIS Global Health Scale, and (3) the Strengths subscale from the CHOIS. Improvement in participants' mental health and recovery was assessed using statistical significance analyses and by evaluating the percentage of participants with applied meaningful improvements on the subscales. Applied meaningfulness is determined using the Minimal Important Difference (MID), which represents the smallest improvement in a scale score that would indicate an observable change in participant health (more detailed information about how MID are calculated can be found here). If the difference between a participant's baseline and follow-up scores on a specific outcome measure is greater than the MID, that participant is considered to have achieved an applied meaningful change for that outcome.

For the CHOIS Strengths subscale, a program is considered to have a positive outcome if participants improve on the CHOIS, or if they maintain a "positive" score during the evaluation period. Many participants were considered "positive" at the baseline assessment, meaning their score indicated that they had many strengths that they could utilize during their recovery process.

Illness Management and Recovery (IMR) Scale: Staff Assessment of Mental Health

Across SHARE! PRISM participants with matched assessments, there were significant improvements on the Recovery and the Management subscale scores from baseline to six months and from baseline to twelve months. On the Recovery and Management subscales respectively, 59.7% and 64.0% of participants had an applied meaningful improvement from baseline to six months. From baseline to twelve months, 60.0% and 60.9% of participants had an applied meaningful improvement on the Recovery and Management subscales, respectively. This indicates that, on average, SHARE! PRISM participants with matched assessments made progress towards their recovery, and improved their ability to manage their mental health six and twelve months after enrolling in the program.





SHARE! PRISM participants experienced significant improvements on several items on the IMR six and twelve months after joining the PRISM program. From baseline to six months and twelve months, participants with matched assessments spent significantly more time in structured roles, such as working, volunteering, being a student, or being a parent, and also engaged in significantly more self-help activities. Staff reported that participants made significantly more progress towards their goals and had significantly more knowledge about symptoms, treatment, coping strategies (coping methods), and medication six and twelve months after enrollment compared to baseline.

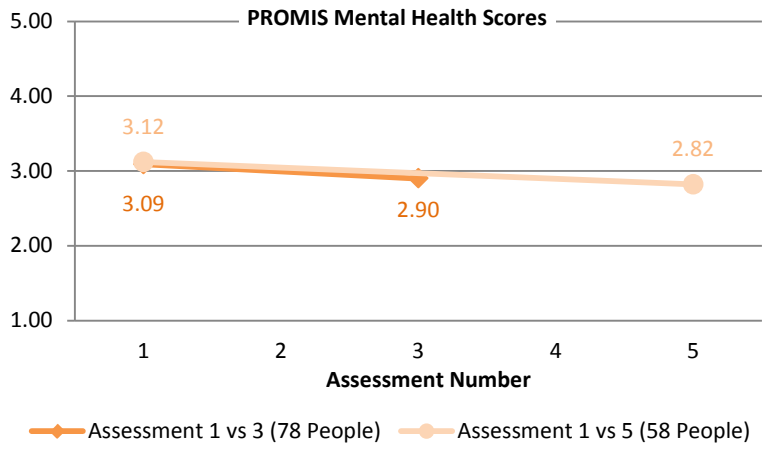
Two items from the IMR were also used to determine each participant's level of social support: "How much are people like family, friends, boyfriend/girlfriend, and other people who are important to the participant (outside the mental health agency) involved in his/her mental health treatment?" and "In a normal week, how many times does s/he talk to someone outside of his/her family (like a friend, co-worker, classmate, roommate, etc.)." From baseline to six and twelve months, SHARE! participants were significantly more likely to have family or friends involved in their treatment and spent significantly more time with people outside their family.

Participant Reported Patient Reported Outcomes Measurement Information System (PROMIS)

The PROMIS Global Health Scale is a 10-item measure aimed at assessing participant reported health including: physical health, pain, fatigue, mental health, and social health. Items are used to create a Total Global Health score and two subscale scores, Physical Health and Mental Health. PROMIS Global Health scores range from 1 to 5; however, participants are also asked to rate their pain using a scale from 0 (no pain) – 10 (worst imaginable pain), which is then categorized into a 5-point scale. For all PROMIS items and scales, lower scores represent fewer health concerns (i.e. lower scores are desirable).

PROMIS Global Health - Mental Health Subscale

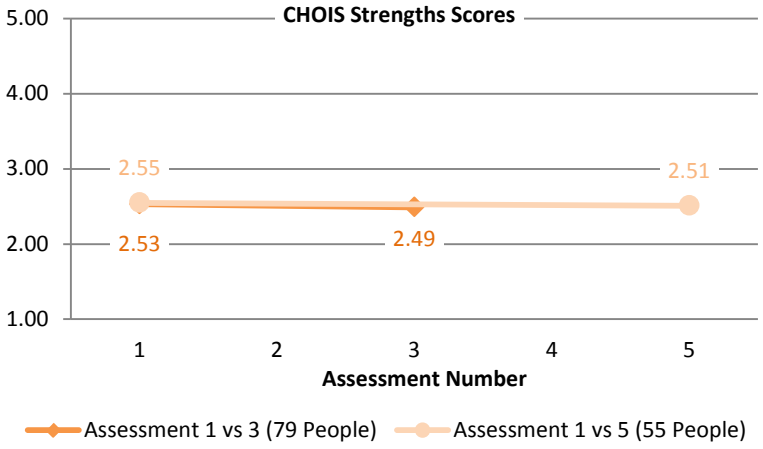
PROMIS Mental Health subscale scores decreased significantly from the baseline to six and twelve month assessments for SHARE! PRISM participants with matched assessments. Many participants had an applied meaningful improvement six months (37.2%) and twelve months (48.3%) after enrollment. This suggests that participants may have experienced improvements in mental health six and twelve months after enrolling in PRISM.



Participant Reported Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS)

The CHOIS Supplement is a participant-rated recovery-based measure that assesses several mental health related domains, including suicidal ideation, anxiety, trauma, and psychosis (i.e. hearing voices). It also includes several items which assess recovery-oriented personal strengths, such as having goals and working towards achieving, feeling good about oneself and living in a home that feels safe. These Strengths can assist participants in their recovery. All CHOIS items and subscales range from 1 to 5, with lower scores being desirable.

Across SHARE! PRISM participants with matched assessments, 24.7% of participants had an applied meaningful improvement in their Strengths subscale scores and 14.1% maintained “positive" levels of Strengths six months after enrollment. Similarly, 26.2% of participants had an applied meaningful improvement and 15.2% maintained “positive” scores from baseline to twelve months. However, there was no significant change in mean CHOIS Strengths subscale scores from baseline to six or twelve months after enrollment.

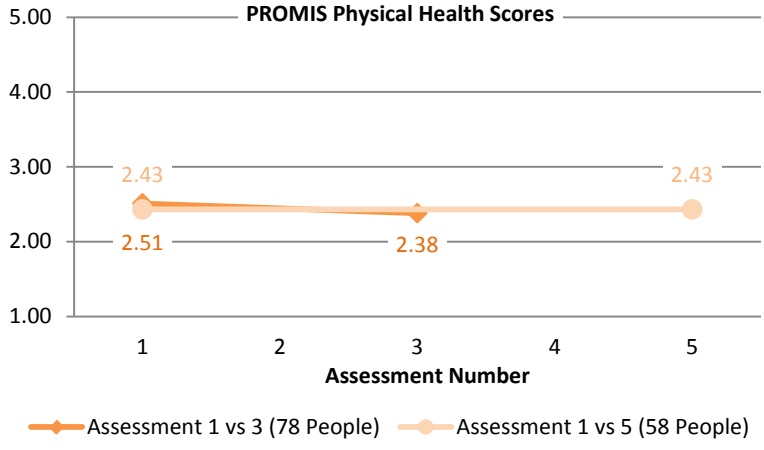


PHYSICAL HEALTH OUTCOMES

Changes in participants’ physical health were assessed using the Physical Health subscale of the PROMIS Global Health Scale.

PROMIS Global Health – Physical Health Subscale

Applied meaningful improvement in physical health was seen for 28.2% of SHARE! PRISM participants with matched assessments from baseline to six months, and 29.3% of participants from baseline to twelve months. While not statistically significant, participants reported experiencing less pain, on average, six and twelve months after enrollment compared to baseline. There were no significant changes in PROMIS Physical Health subscale scores from the baseline to the six or twelve-



month assessments for participants with matched assessments.

SUBSTANCE USE OUTCOMES

Changes in participants' substance use were assessed using the PROMIS-Derived Substance Use Scale, which assesses the participant's perception of the negative consequences of their substance use. All participants were also asked how frequently they used alcohol or illegal substances. Improvement was also tracked using the IMR Substance Use Subscale, which asks staff to rate how much alcohol and drugs affect the participant. Improvement in substance use was assessed by using statistical significance analyses and evaluating the percentage of participants who maintained "positive" ratings or made applied meaningful improvements on the PROMIS-Derived Substance Use Subscale, and the IMR Substance Use Subscale. Participants were also considered to have positive outcomes for substance use if they maintained no alcohol or substance use, or reduced their use over the evaluation period.

Participant Reported Substance Use Items

Participants reported how frequently they used alcohol and illicit drugs on the Physical Health and Behaviors Survey.

At baseline, most participants reported that they had not used an illegal drug (74.7%) or consumed alcohol (52.5%) in the past six months.

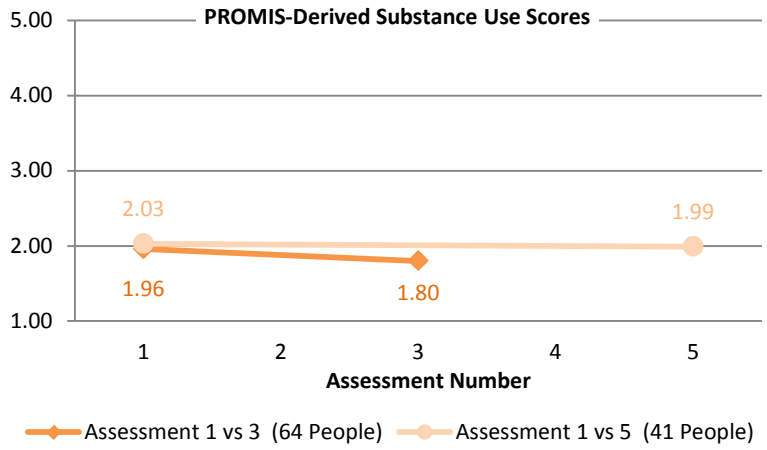
In the past 6 months…	Never	Less than once a week	1-3 times per week	4 or more times per week	Every day
How often did you have any kind of drink containing alcohol, such as beer, wine, or liquor?					
Baseline Assessment (N=240 People)	52.5%	27.5%	15.0%	2.1%	2.9%
How often did you use an illegal drug or use a prescription medication for nonmedical reasons?					
Baseline Assessment (N=241 People)	74.7%	10.8%	7.5%	5.4%	1.7%

For SHARE! PRISM participants with matched assessments (N=78), 23.7% of participants had applied meaningful improvements in alcohol consumption and 17.9% had applied meaningful improvement in illegal drug use six months after enrollment compared to baseline. SHARE! PRISM participants (N=60) had similar meaningful reductions in alcohol and illegal drug use from baseline to twelve months (22.0% and 21.7%, respectively). Additionally, many participants with matched assessments reported maintaining no alcohol use from baseline to six months (39.5%) and from baseline to twelve months (40.7%). More than half of participants with matched assessments reported maintaining no illegal drug use from baseline to six months (59.0%) and from baseline to twelve months (58.3%). However, there were no statistically significant changes in average alcohol consumption or illicit drug use among SHARE! PRISM participants from the baseline to the six or twelve-month assessment.

Participant Reported Substance Use: PROMIS-Derived Substance Use

The 12-item PROMIS-Derived Substance Use measure assesses participants' perception of negative consequences of their alcohol and/or other substance use. Item and total scale scores range from 1 to 5, with lower scores being positive as they indicate fewer perceived consequences associated with alcohol and/or other substance use.

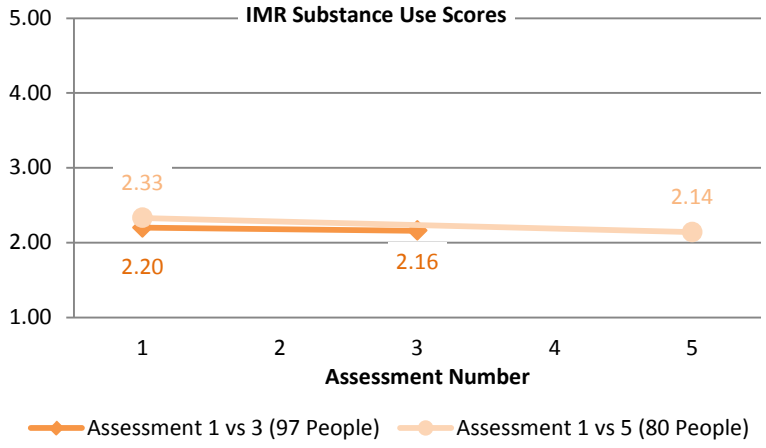
For SHARE! PRISM participants with matched assessments, 45.3% maintained no or relatively few perceived negative consequences from substance use and 25.0% of SHARE! PRISM participants had an applied meaningful reduction in negative consequences associated with alcohol and/or drug



use six months after enrollment compared to baseline. From baseline to twelve months, 31.7% maintained no or relatively few consequences from substance use and 31.7% of participants had an applied meaningful reduction in negative consequences associated with alcohol and/or drug use compared to baseline. However, there was no statistically significant change in mean PROMIS-Derived Substance Use ratings from the baseline to the six and twelve-month assessments for participants with matched assessments.

Staff Reported Substance Use: IMR Substance Use Subscale

For SHARE! PRISM participants with matched assessments, 22.7% of participants had an applied meaningful improvement on the IMR Substance Use Subscale from baseline to six months, and 25.0% had an applied meaningful improvement in scores from baseline to twelve months. However, there were no statistically significant changes in IMR Substance Use scores from baseline to six and twelve months for all PRISM participants with matched assessments, as well for those who were identified by staff as being impacted by substance use during the same time periods.



QUALITY OF LIFE OUTCOMES

While there are many indicators of participant quality of life, the current evaluation focused on incarcerations, participant reports of emergency service use and hospitalization, constructive activities such as employment, volunteer work, enrollment in school, housing, housing retention, and mental health stigma. To determine participant improvement, statistically significant changes in quality of life outcomes were assessed. Improvement was also assessed by examining the proportion of participants who maintained "positive" ratings or made applied meaningful improvements on the quality of life outcomes. Examples of participants with "positive" assessments included those with: no emergency service use, no incarcerations, or who maintained current employment.

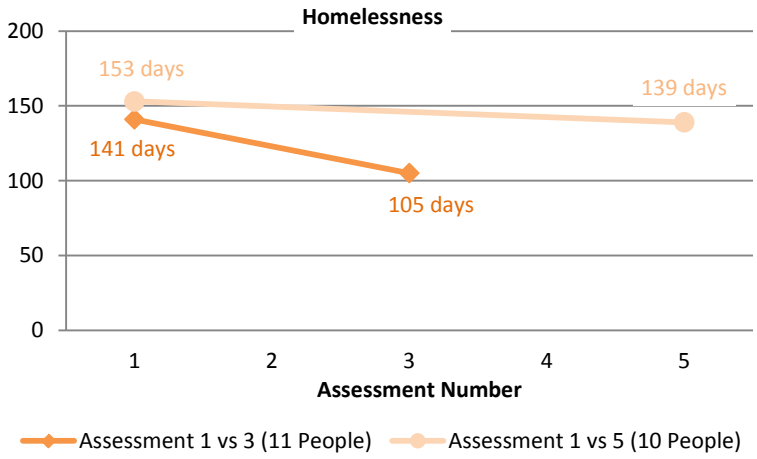
> *"We have one gentleman that was chronically homeless and we paired him with SCHARP which is a Full Service Partnership…we were working closely with them to make sure that he went to his appointments. It got to the point that he got confident enough to be on his own so he wanted to go live with his dad. He has not lived with his dad in over 15 years. He packed up and went to live with him near San Diego. Because of his involvement here, he was able to have that confidence to reconnect with his family and not be alone anymore."* – SHARE! Staff Person

Homelessness

Staff report each participant's experience with homelessness as part of the Staff Assessment.

At the baseline assessment, many SHARE! PRISM participants (42.6%) were homeless during the prior six months. Additionally, 28.1% of participants experienced chronic homelessness (defined as being homeless for at least 4 of the previous 6 months) before enrolling in SHARE!.

From baseline to six months (N=32), 43.8% of participants maintained no homelessness and 25.0% of participants had an applied meaningful reduction in number of days spent homeless. From baseline to twelve months (N=32), half of participants (50.0%) maintained no homelessness and 15.6% had an applied meaningful reduction in number of days spent homeless. While not statistically significant, for participants with reported homelessness at baseline and six-month assessment and baseline and twelve-month follow-up assessments, there was a reduction in the average number of days spent homeless.



"We had one woman that was getting evicted from her Section 8 apartment because she had bed bugs and roaches. We had to move her to another apartment. She is a hoarder and won't give up a piece of anything. We have to move her from one place to another place and not end up with bedbugs and roaches [at the new place]. We were able to put that [move] together with volunteers. We hired homeless people…We had to bag everything multiple times. We had to take all of her clothes to a laundry mat. She had a Full Service Partnership and she was going to be homeless again because they don't have the resources to do the whole thing."
– SHARE! staff person

Incarcerations

Participants reported how often they were incarcerated on the Physical Health and Behaviors Survey. At baseline, the majority of participants reported that they had not been incarcerated in the past six months (85.5%).

During the past 6 months, how many times were you sent to jail or prison?					
	None	1-3 times	4-6 times	7-10 times	More than 10 times
Baseline Assessment (N=242 People)	85.5%	12.0%	2.1%	0.0%	0.4%

For participants with matched assessments from baseline to six months (N=79), 74.7% of SHARE! participants maintained no incarcerations and 13.9% of participants had an applied meaningful reduction in incarcerations. Twelve months after enrollment (N=59), 74.6% of SHARE! PRISM participants maintained no incarcerations and 13.6% of participants had an applied meaningful reduction in incarcerations. However, there were no statistically significant changes in incarcerations from baseline to six and twelve months for SHARE! PRISM participants with matched assessments.

Emergency Services and Hospitalizations

Participants reported how often they used emergency or hospital services on the Physical Health and Behaviors Survey. At baseline, more than half of participants (63.5%) reported that they had not been gone to an emergency room and 73.3% reported that they had not been hospitalized during the past six months.

In the past 6 months…	None	1-3 times	4-6 times	7-10 times	More than 10 times
How many times did you go to an emergency room?					
Baseline Assessment (N=241 People)	63.5%	30.3%	4.1%	1.2%	0.8%
How many times were you admitted to a hospital?					
Baseline Assessment (N=240 People)	73.3%	22.9%	2.9%	0.4%	0.4%

For participants with matched assessments from baseline to six months (N=78), 26.0% of SHARE! participants reduced the number of emergency room visits and 19.2% reduced the number of hospital visits. During the same time period, 46.8% and 61.5% of participants maintained no ER or hospital visits, respectively. Twelve months after enrollment (N=59), 42.4% of SHARE! participants maintained no ER and 56.9% maintained no hospitalizations; 28.8% of participants had an applied meaningful reduction in ER visits and 22.4% of participants had an applied meaningful reduction in hospital visits. There was also a statistically significant reduction in emergency room utilization twelve months after enrollment for participants with matched assessment. However, there were no statistically significant changes in emergency room visits from baseline to six months, or in hospital utilization from baseline to six and twelve months for all PRISM participants with matched assessments.

Constructive Activities

On the Physical Health and Behaviors Survey, participants were asked to indicate if they had engaged in paid employment, participated in volunteer activities, or attended school in the previous six months.

During the past 6 months, which of the following have you done?	
	% Engaged
Have paid employment?	
Baseline Assessment (N=241 People)	30.7%
Participate in volunteer activities?	
Baseline Assessment (N=239 People)	58.6%
Attend school?	
Baseline Assessment (N=240 People)	24.2%

More SHARE! PRISM participants reported engaging in volunteer activities on the baseline assessment than engaging in paid employment or attending school. For SHARE! participants with matched assessments from baseline to six months (N=74), 18.9% of participants gained employment while 20.3% maintained paid employment, 22.4% of participants started a volunteer activity while 48.7% continued to participate in volunteer activities and 5.6% of participants started attending school while 13.9% continued to attend school. Twelve months after enrollment (N=57), 29.8% of participants with matched assessments gained employment, 24.6% participated in new volunteer activities and 14.3% of participants started attending schools.

> *"I showed up today at one young lady's house that I have not seen in a while because she comes to an afternoon meeting here. Her roommate comes …and then she starts telling me about all these accomplishments her roommate has made. She is graduating from a training program. She is working a full time job. She has developed a relationship with her mother. She is helping her support her brother and her health issues. All of these emotional changes that she [the roommate] has seen happen in her life since she has been participating in SHARE!. When I talk to this young lady, her conversations are like 'oh yeah, things are better. I am going to school and I am working.' She does not see for herself the changes that other people are seeing. To me that it is amazing…"* - SHARE! staff person

SATISFACTION

The participant-completed Feedback Survey was administered to contribute to our learning about participants' experiences with the peer-run program, and to help staff make ongoing quality improvement plans to ensure participants benefit from the support and recovery environment. In general, satisfaction with the SHARE! PRISM program was high. Satisfaction at six month and twelve-month follow-up assessments was similar, so only ratings at twelve months are included in the table below. Most of the participants who completed the Feedback Survey twelve months after enrollment agreed that there are people available to talk with as often as they felt was necessary (91.0%), and that the program respected their cultural needs (88.1%). Most participants who completed the survey agreed that the program helped them achieve their goals and helped empower them to make positive changes in their life (88.1%).

However, participants were less likely to agree with some items on the Feedback Survey. Participants were least likely to endorse the item: "I participated in activities with others in the community of my choice (69.7%)." However, a goal of peer staff is to empower participants to find resources and linkages themselves, rather than relying on staff to be a problem-solver. Finding resources is dependent on the participant's motivation and not the program.

Peer staff wanted to assess participants' feelings of self-efficacy. Two items were developed by the evaluation team with the peer staff to assess this domain. Twelve months after joining PRISM, most SHARE! participants reported that they had average level of self-esteem (20.6%) and many participants (41.3%) reported having high level (ratings between seven and 10, on a scale of zero to 10) of self-esteem. Most participants reported feeling either some control (25.0%) or a high level of control (ratings between seven and 10, on a scale of zero to 10) six months after enrollment in the program (52.9%).

SHARE! PRISM Guest Feedback Survey			
	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
I like coming to this program.			
Twelve Month Assessment (N=68)	0.0%	11.8%	88.2%
If I had other choices, I would still come to this program.			
Twelve Month Assessment (N=67)	4.5%	10.4%	85.1%
People were available to talk with me as often as I felt it was necessary.			
Twelve Month Assessment (N=67)	4.5%	4.5%	91.0%
I feel safe when I am at this program.			
Twelve Month Assessment (N=67)	1.5%	16.4%	82.1%
As a result of this program I feel empowered to make positive changes in my life.			
Twelve Month Assessment (N=67)	1.5%	10.4%	88.1%
This program helps me reach my goals.			
Twelve Month Assessment (N=67)	0.0%	11.9%	88.1%
This program respects my cultural needs (race, religion, language, etc.).			
Twelve Month Assessment (N=67)	1.5%	10.4%	88.1%
My mental health, physical health, and substance use concerns are addressed.			
Twelve Month Assessment (N=67)	4.5%	16.4%	79.1%
My beliefs about health and well-being were respected in this program.			
Twelve Month Assessment (N=66)	6.1%	15.2%	78.8%
I have found referrals to resources that assisted me and/or my family.			
Twelve Month Assessment (N=65)	3.1%	9.2%	87.7%
I participated in the decision making about my recovery and wellness.			
Twelve Month Assessment (N=66)	4.5%	13.6%	81.8%
As a result of this program, I deal more effectively with daily problems.			
Twelve Month Assessment (N=67)	4.5%	10.4%	85.1%
Participating in this program has made me more effective in my relationships with family and friends.			
Twelve Month Assessment (N=66)	4.5%	18.2%	77.3%
After coming to this program, I am better able to work towards my life goals.			
Twelve Month Assessment (N=66)	3.0%	10.4%	86.6%
I feel comfortable talking about personal matters with peer staff.			
Twelve Month Assessment (N=66)	1.5%	11.9%	86.6%
I participate in activities with others in the community of my choice.			
Twelve Month Assessment (N=66)	4.5%	25.8%	69.7%

Please rate your current level of self-esteem using the scale below. (Twelve Month Assessment=68 People)										
Very low	1	2	3	4	Average	6	7	8	9	High
2.9%	1.5%	2.9%	2.9%	14.7%	20.6%	13.2%	11.8%	16.2%	5.9%	7.4%

Please rate how much control you have over your life using the scale below. (Twelve Month Assessment=68 People)										
No control	1	2	3	4	Some control	6	7	8	9	Complete control
4.4%	0.0%	0.0%	2.9%	4.4%	25.0%	10.3%	11.8%	17.6%	8.8%	14.7%

PRISM MODEL DISCUSSION

Unlike PRRCH, PRISM did not have other programs across the country to learn from and model itself after. Instead PRISM was designed through discussion between the peer providers and LACDMH. While PRISM's resource center concept was articulated early in program planning, what that concept meant and how it would be operationalized evolved over time based on providers' learning and participants' needs. In addition, monthly gatherings of the peer providers, LACDMH staff, and the evaluation team – "peer roundtables" – helped inform the design and implementation of the PRISM. Through sharing challenges and successes, brainstorming solutions, and discussing evaluation data and training needs, the peer providers helped support each other through the design and implementation of PRISM as well as PRRCH.

Overall, PRISM participants were very diverse, but in some ways they were similar to clients from the other INN models. Participants were from a wide range of ages and ethnicities. Compared to the other INN models, on average, the overall mental health of PRISM participants as recorded on the IMR was less impaired than for clients from the other models, while physical health was comparable. SHARE! and Project Return participants were more likely to report consuming alcohol or using drugs on the Physical Health and Behaviors Survey than clients in the ICM or ISM models. It is possible that participants were more honest when reporting their substance use because of the relationships and trust that peer staff work to establish with individuals. Although Project Return participants reported higher levels of stigma at baseline than SHARE! participants, PRISM participants overall had stigma rating that were slightly lower than clients in the other INN models.

During the Provider Focus Groups, PRISM staff shared the primary implementation challenges, how they were overcome, and suggestions for how to most effectively continue the programs. There were many similar challenges and suggestions across providers, so their responses have been combined below. This section also highlights some of the unique program design elements of each provider's program. For example, the providers utilized different methods for outreach and engagement and communication with participants.

Hiring and Training Staff: During the Provider Focus Groups, staff from both PRISM providers shared that they had difficulties either hiring qualified peer staff, or maintaining consistent staffing. Peer model supervisors at LACDMH also noted these challenges in their interviews. Peer providers noted that the typical 90 day hiring time period for new LACDMH projects is not enough time to find and train peer staff. Peer model supervisors and peer providers at LACDMH regularly discussed their staffing challenges at monthly peer roundtable meetings. During those meetings, they shared lessons and solutions to learn and support each other in solving this challenge.

Project Return staff noted that staffing changes caused a lack of program clarity, accountability, and structure. This then impacted the program's outreach and program implementation because there was not enough staff to do outreach. Peer model supervisors at LACDMH also noted the challenges from the leadership and organizational changes at Project Return. Specifically, they highlighted the impact of the organization's transition to become a separate legal entity from Mental Health America – Los Angeles.

Although SHARE! staff experienced little turnover once fully hired, they reported that it was difficult to find qualified staff. They highlighted the importance of hiring peers with a combination of training and personal experience in self-help support groups versus peers that are only trained through courses. Experience with self-help support groups ensures that staff have developed their own coping skills and support system to help them handle personal triggers that may come up as they work with participants. Most SHARE! staff have at least two to five years of involvement with support groups. Staff also stressed the importance of the peer having their own recovery and support system to handle the stress of the job. *"…I hire people who do not have a high school diploma, or just a GED, or with just a high school diploma because they have worked on themselves emotionally to be able to be in a place where they can be there for someone else without crashing and burning."*

Several qualities were highlighted as vital for a successful peer staff member:

- Having lived experience (for management/leadership to support staff, and for all other staff to support participants)
- Experience in the mental health field
- Experience attending self-help groups for at least one year
- Having their own recovery and support system

During the Provider Focus Groups, staff at SHARE! described the benefit of using their peer-run respite as a training opportunity for all SHARE! staff. SHARE! management felt that providing staff with experiences in an intensive support program made the person a better SHARE! employee. The peer-run respite helped them see the bigger picture and the impact of the organization's work.

Both providers also highlighted the need for additional trainings from LACDMH specific to peer support services to support them in their role. They wanted training to be offered early in the program and more frequently to accommodate new hires. Peer staff would like more training from LACDMH to help support the integration of peers into the mental health system and enhance their roles. Several essential trainings listed included:

- Intentional Peer Support (IPS) to develop the skills and the mindfulness to be an effective peer in these programs
- Peer Advocate Certificate training
- Wellness Recovery Action Plan (WRAP)

The importance of hiring and training of leadership was especially important for staff at Project Return. The provider had several rounds of turnover at the leadership level. During the Provider Focus Group staff shared that they felt isolated and unsupported during that time of transition. However, the program is now led and fully run by peers and staffing has stabilized. The current team feels more collaborative and supportive of each other professionally and emotionally with common understanding of the program's priorities and the important role they each play as peers.

Outreach and Engagement: Staff from both PRISM programs found outreach and engagement to be a great challenge, and it took time and experimentation to figure out what worked and what did not. They wish there had been more initial planning and outreach time so that they could have experimented more with different outreach methods. From this process, staff learned the importance of building community partnerships to build an outreach network.

Both providers developed collaborations with other agencies to support their participants or to enhance their outreach efforts. SHARE! staff reported that they found it beneficial to partner with national recovery organizations such as Recovery International, and local programs, such as the Center for Collective Wisdom. Project Return now has people co-located at a community organization, ROADS. Staff described outreach as a constant process. If they are at a gas station or see a homeless person they share a flyer about the program.

SHARE! staff felt significant stigma and discrimination against peer programs by traditional healthcare providers. One staff person noted that LACDMH could play a role and help peers services be more integrated within the overall system of care in order to encourage referrals to PRISM programs. *"If they [LACDMH] could have just said 'we have this new level of care that is part of Innovations...for people who cannot go to Full Service Partnership, this is where you could send them.' We would have been inundated with referrals but instead we got less than 20 over 3 years."*

Peer model supervisors at LACDMH stressed that both providers had very strong skills building trust and rapport with participants, which they saw as an important skill for participant outreach, engagement, and retention. The model supervisors felt that over time the providers were able to successfully build relationships and reach their target populations. Overall, model supervisors observed great progress with referrals to the program over the past two years. Even with the challenge of stigma, they noted that both providers have received referrals and built referral relationships. As one model supervisor said, *"Sometimes I think that they struggled with being an equivalent partner to the other providers that were there. But I think that over time they overcame."* Model supervisors are seeing a shift as traditional care providers come to understand the important role and added value of the peer programs over time.

They noted that acceptance has improved over the course of this two year program but still has more progress to make over time.

Integration: In the Provider Focus Groups, staff from both providers described how peer staff should be more integrated into the overall system of care, and provide more input in treatment plans. Both PRISM providers shared frustration with their current roles and level of respect from traditional providers across Los Angeles County. They believe that there is not respect for peers among mental health providers, which prevents them from becoming integrated into mental health services. As one staff person shared, *"If a psychiatrist is a specialist of the brain, we are specialists in the recovery process. We should be seen as specialists. We are not seen as having an important role."* Program staff shared that they currently feel that they are an afterthought and separate from the system of care. Staff also shared concerns about the lack of understanding about peer support services. For example, staff highlighted that some other community providers want peers to be the person to kick people out of housing, act as the "police" or write up their issues, which are challenging and inappropriate roles for a peer. Staff highlighted the benefit of incorporating evidence-based practices to help decrease stigma and train programs about effective ways to incorporate peer support services into their organization. Addressing stigma against peer programs and establishing a better understanding of peer support services and their benefits would improve integration into the overall system of care.

Staff shared during Focus Groups that peers could be cost efficient by freeing up other staff time and reducing burden on the system. Many LACDMH programs currently incorporate peer support services, including the other INN models of care, Full Service Partnerships, Community Services and Support and Case Management. The peer staff suggested that peers could perform the following activities:

- Connect with people to provide social support for clients
- Serve as peer health navigators to provide a safety net for people just released from jail.
- Act as part of a FSP or wellness team

Peer staff highlighted the important social support role they play by having genuine conversations with people, listening, and connecting with them as someone who has lived experience with mental health issues and substance abuse. The PRISM program provides a unique environment for participants to gain social support by connecting them with other people through self-help support groups to help build their network of support. By focusing on building trust with people, peer staff are able to have genuine connections with participants, which helps people openly share their challenges and needs with staff. Staff remember these conversations and retain that information so that they can follow-up and reconnect with the person the next time they see them. In addition to incorporating peers into existing health care providers, peer providers such as SHARE! or Project Return could partner with other providers to serve these roles. Staff see their social support role as vital to LACDMH's work and the entire system of care. However, staff cautioned against asking peers to be the person to have participants' complete forms. This is challenging to them because of the sensitive or intrusive nature of the questions and they do not want to be viewed as an authority figure. As one staff person noted, *"That [filling out forms] has been really hard for us… It interferes with our relationships. We try to do it in the best way possible. There are some relationships that we have ruined because of that aspect."*

Communication with Participants: Project Return and SHARE! each had different methods of communicating with participants. As both programs were able to successfully communicate with their participants, it appears that different techniques may be effective. While this may be dependent on the specific participants involved with each program, the communication styles also varied according to the different providers' organizational cultures with one provider preferring more structured and scheduled communication and the other provider less structure. Peer staff highlighted some specific learning about the communication style during Provider Focus Group Interviews.

- Appointments: SHARE! staff noted that at the beginning of the program they scheduled specific appointments with participants. However, most people were not showing up for their appointments with staff. Staff felt that making appointments was not consistent with the SHARE! environment. As one SHARE! staff person explained, *"…SHARE is home. You don't make an appointment at home. I don't make an appointment with my husband, my son, or my sister to talk about how we are going to do things differently. It was too formal for the whole thing."* Staff highlighted that this was a big learning for them as an organization. For some of their other programs, such as their housing program, they make appointments with people and it works well. Staff felt that participants came to SHARE! looking for a different space and environment than their mental health appointments and a different space and environment. Therefore, the program changed to regular communication with participants and reaching out to them on an on-going basis instead of scheduled appointments. However, Project Return was successful scheduling regular meetings with participants. This may be because they had a greater number of veterans who were more accustomed to having a schedule. Project Return was also successful in assisting individuals in accompanying them to their scheduled appointments, such as with their primary care doctors, DMV appointments, or DPSS office appointments. They were able to achieve this by expressing the importance of showing up to appointments if they wanted to achieve their goals.

- Team approach: SHARE! intentionally did not assign individual staff contacts to participants. Instead they used a team approach. Staff felt that this was beneficial in helping drop-in participants and prevented participants from being tied to the schedule of a single staff member. In addition, this team approach helped participants connect with multiple people and find the people they preferred to talk with. However, SHARE! staff highlighted that it took time to determine the best team communication methods and mechanisms to support each other. *"The first people that we signed up went to support groups at SHARE! and did all the things that we would have liked them to have done. We were having an impact on them more than someone just walking through our door. It was not until later that we figured out how to have the peer progress meeting [to discuss] if someone was not doing well towards their goal. We could figure out how do we get this guy who is using drugs, who is homeless, who is refusing to take mental health medication, how to we get him to change his mind."* Project Return chose the different approach of encouraging each participant to work with a specific staff member who they connect with. The staff member works with the participant closely and communicates with them through regularly scheduled meetings, and also discussed specific challenges or needs with other staff to brainstorm solutions.
  Home visits: As part of their regular, unscheduled communication with participants, SHARE! staff also conducted home visits. Staff noted that home visits were highly appreciated by participants and provided a way to get to know the person in a comfortable environment. For example, one staff person shared about visiting a women at her house: *"She was slightly pregnant and as her pregnancy grew she kept coming and then she did not show up. We showed up at her house and I was not sure if it was going to work because I haven't seen her in a while but we had a good relationship when she was here. Unbeknownst to me, she had a cesarean and the last part of her pregnancy had been problematic. She had so many things going on that she almost broke down to tears when she saw us. 'I am so glad to see you.' She let us in. We sat down. It was really great…I get a lot more information on people in their territory than I necessarily do here because here they are comfortable but they are still guarded with what they share. At home, they are more comfortable. They are in their socks. Their hair is not done. They get more involved in their future because they see that SHARE! is invested in them and they want to become more active."* Project Return also conducted home visits, but noted that meeting with individuals in the community was their primary method for meetings.

LACDMH Connections and Linkages:

PRISM providers each experienced challenges with obtaining resources and referrals to meet participants' needs. Staff noted that some participants required a higher level of care and had more housing needs than they anticipated. Specifically, they had participants in need of Section

8 housing, people who were homeless, and people with other severe physical health and mental health concerns. Both SHARE! and Project Return shared different challenges supporting their participants' housing needs.

Project Return staff found it challenging to link all the people who desire better housing to temporary housing or permanent supportive housing due to lack of disability or social security benefits. In addition, peer providers believed that individuals who were viewed as combative and negative were less likely to get accepted into housing. Project Return staff highlighted that more connections and support from LACDMH related to housing and social security benefits would have been helpful to the program. Specifically, the staff suggested that LACDMH directly provide the programs with housing vouchers instead of requiring participants to work with another LACDMH provider to obtain housing vouchers. The staff shared that it was a challenge to support people without vouchers to give to them directly. Peer staff attempt to find as many resources as possible for participants themselves to reduce barriers to care. As one staff person shared, *"We don't want anyone in a higher level of care unless they absolutely need to be there."* Project Return staff shared that their organization is less structured and works differently than LACDMH, which made the approval process and paperwork required by LACDMH feel like a barrier for them to address people's immediate needs in a responsive and timely manner.

SHARE! staff highlighted that connecting participants to housing and other services was a great challenge, and they believe that stigma about peer programs was the main reason. Staff shared that when they referred participants to other providers, the providers did not take their referrals and requests seriously because they are not clinicians. For example, staff noted that in SHARE! Downtown Los Angeles there are about fifteen to twenty people who they felt need to be in Full Service Partnerships (FSP) and after being referred were not accepted. The staff noted that they needed more connections with and support from LACDMH staff and other service providers to ensure that PRISM participants in need of higher levels of care have access to the proper resources.

OVERALL DISCUSSION (PRRCH AND PRISM)

PRRCH and PRISM discussion sections highlight specific lessons learned from the peer providers' perspectives, such as staffing and training, communication with participants, and outreach and engagement. Below are key lessons across both PRRCH and PRISM programs. They are informed by a Focus Group with LACDMH peer model supervisors and the Provider Focus Groups.

Learning Focus

LACDMH peer model supervisors stressed the importance of the programs being learning focused, with providers and LACDMH all learning from and with each other. Model supervisors supported this learning environment by reiterating the learning focus at monthly peer provider roundtable discussions, providing regular training opportunities, and encouraging the use of evaluation data and observational data to conduct continuous program improvement. The learning focus helped the model supervisors shape their relationship with the providers over the course of the project into a partnership rather than a hierarchy. Early on, the providers asked the model supervisors to tell them specific solutions to challenges; however, over time, the providers became more comfortable sharing potential solutions and collaborating with the model supervisors. Program staff would regularly call or email the peer model supervisors with issues and challenges, which helped build a relationship of mutual trust. As one model supervisor stressed, *"We are invested in their existence and they are very critical to the evaluation of peer services…We were trying to create an interconnectedness in the providers and the larger system of care."*

General Training Recommendations

In the Provider Focus Groups, both providers identified a need for additional training from LACDMH that is specific to peer services to support them in their role. They wanted training to be offered early in the program and more frequently to accommodate new hires. Peer model supervisors at LACDMH agreed, and also described the importance of providing customized trainings for peer programs and collaboratively developing a training schedule with providers. Early in implementation, some trainings, including both program trainings and evaluation trainings, were more general and not targeted to or inclusive of peer staff. In addition, some trainings were not well received by peer staff, such as Motivational Interviewing (MI), which was viewed as too clinically focused and not appropriate for peer relationships, which are more about listening than asking questions. The peer providers expressed their frustration to the model supervisors, which caused them to change the approach to become more customized and collaborative. For example, LACDMH and the evaluation team learned that it is important to consider specific terminology used in trainings (e.g., client or clinical). In addition, it is important to be collaborative with programs when deciding which trainings might be beneficial and how and when they should be implemented. Model supervisors also feel that it is important to include active dialogue in trainings and time for the people to voice their opinions and thoughts, versus trainings in which attendees more passively listen to presenters.

Peer staff identified several trainings as essential including:

- Intentional Peer Support (IPS) training to develop the skills and the mindfulness to be an effective peer in these programs
- Peer Advocate Certificate training
- Wellness Recovery Action Plan (WRAP) training

Both providers found some trainings helpful. While in other instances one provider found it helpful while another did not. Both providers shared that the Mental Health First Aide training was useful to staff. The Mental Health First Aide training provided staff with insight on how a person in crisis may feel, especially when they are hearing voices. Project Return found the Health Navigator training helpful. Staff shared that the training taught them how to help people navigate the medical model of care system. However, SHARE! found the training focused on the professional delivery of services and not appropriate for their program. Project Return staff noted that some of the benefits trainings were useful to staff, such as the Understanding Social Security Process training. Staff shared that the

training provided them with a better understanding of how to navigate the benefits process with participants and not feel intimidated by it. SHARE!'s staff highlighted their internal training, the Tools of the Trade, as essential to teach staff how to deescalate conflict. Using the Tools of the Trade, staff learn, and help participants see, that social connectedness is linked with improvements in income, housing, well-being and marked decrease in institutionalization. SHARE! also appreciated other trainings such as COS Billing, Mental Health CPR, and the Milestones of Recovery (MORS). Several of the trainings appreciated by the peer providers were also identified by peer model supervisors at LACDMH as potential trainings to implement across LACDMH, including in wellness centers.

There have been two toolkits recently developed[6,7] for peer providers and for evaluating peer respite programs. While these toolkits were not available during the implementation stages of this evaluation, these could be beneficial resources for future programs as they include lists of training resources and methods for measuring success.

Implementation

Outreach, engagement and referrals: Staff from both providers found outreach and engagement to be a great challenge, and it took time and experimentation to figure out what worked and what did not. Peer staff shared that they wished there had been more initial planning and outreach time so that they could have experimented more with different outreach methods. Staff shared the importance of building community partnerships to build an outreach network. Peer model supervisors at LACDMH stressed that both providers had very strong skills building trust and rapport with participants, which they saw as an important skill for participant outreach, engagement, and retention. The model supervisors felt that over time, the providers were able to successfully build relationships and reach their target populations.

Both providers developed collaborations with other agencies to support their participants or to enhance their outreach efforts. SHARE! staff reported in the Provider Focus Groups that they found it beneficial to partner with national recovery organizations, such as Recovery International, and local programs, such as the Center for Collective Wisdom. Project Return was partnered with Mental Health America – Los Angeles, a LACDMH service provider. Project Return also has people co-located at a community organization, ROADS.

When conducting outreach, SHARE! staff experienced significant stigma and discrimination against peer programs by traditional healthcare providers. SHARE! program staff regularly attended the Impact Unit meetings to discuss the benefits of PRISM and PRRCH and to develop referral relationships with other DMH programs.. As one staff person noted, *"It is like we are still 'other'…As long as DMH doesn't take proactive steps to counter that, then the norm is not to involve oneself with peers, even the people that want to work with peers are peer pressured to not do so. The fact that we have to work so hard to get people to come to the retreat even though we have such great outcomes. There is stigma attached to our program because our name includes peer. There needs to be action taken to counter this."*

Overall, peer model supervisors observed great progress with referrals to the program over the past two years. Even with the challenge of stigma, they noted that both providers have received referrals and built referral relationships. As one model supervisor said, *"Sometimes I think that they struggled with being an equivalent partner to the other providers that were there. But I think that over time they overcame."* Model supervisors saw a shift as other care providers came to understand the important role and value of the peer programs over time. They noted that acceptance has improved over the course of this two year program but still has more progress to make over time.

Program location: Peer model supervisors at LACDMH shared the importance of program location and its relationship to outreach and engagement. Both providers spent significant time selecting the locations of their programs, particularly the location of their respites. Peer staff wanted to find a location with a high target population density to ensure that participants would not have to travel far to receive support or to follow up on referrals. For

[6] Meaningful Roles for Peer Providers in Integrated Healthcare: A Guide; 2014. Access from www.casra.org/docs/peer_provider_toolkit.pdf

[7] Ostrow L, Croft B. Toolkit for Evaluating Peer Respites. Lawrence, MA: National Empowerment Center; 2014.

PRRCH guests, staff also wanted to ensure that guests would not have to travel far to participate in the same support groups and activities after leaving the respite. Peer model supervisors highlighted that the peer model reinforced to them how program location can help with outreach and engagement. Specifically, model supervisors learned that selecting a location with an existing community infrastructure is helpful because it can benefit the referral process. For example, Project Return's location in Long Beach at the Century Villages at Cabrillo was beneficial to the program because it immediately connected them to a well-connected provider network in the community. Peer model supervisors stressed that when creating a peer program, location should be selected carefully.

Billing: Peer model supervisors at LACDMH shared that billing for peer support services, particularly for overnight stays in the respite, was a challenge for both the providers and for LACDMH. Model supervisors carefully looked for solutions; however, this issue has not yet been resolved. They learned the importance of communicating challenges and collaboratively discussing with the peer providers how to improve the situation within overall country constraints. Many of the costs associated with the peer programs do not fit with traditional billing options, such as paying staff hourly instead of on an appointment schedule and purchasing groceries and other household goods for the respite. Other counties should consider how they will fund and bill for peer support services while working within existing systems.

Program specific learning: Each program shared some program specific challenges and learning during Provider Focus Groups. At SHARE!, staff highlighted that the original tool they developed to document and track a person's recovery did not work as hoped and they abandoned it after a few months. SHARE!'s Recovery Tracker was intended to help identify which support groups or support in general might be beneficial or relevant to a specific person. As one staff person shared, *"I loved the idea that the evaluation tool was also the implementation tool and that the person could use it for their own purposes. I loved all of that."* However, staff highlighted that the Recovery Tracker's reading level was higher than most participants' reading level. They shared that they also realized that the Recovery Tracker worked best for people further along in their recovery. Since the program was targeting people new to recovery, it was frustrating, shaming, or depressing for people to complete the form and see how early they were in recovery. Therefore, staff quickly discontinued using the Recovery Tracker.

EVALUATION CHALLENGES

The current evaluation was intended to provide the same rigor as the evaluation of the other INN models of service. This is rare for peer-run programs, which often face institutional barriers to evaluation. While all programs have challenges related to evaluation, there were several unique challenges for this evaluation. For example, peer staff are relate to program participants as people with lived experience. This is a central element in helping to build rapport and trust that will empower participants to make goals and seek tools to aid in their recovery. The measurement tools that are typically employed in this kind of evaluation research seem contradictory to this philosophy, as they require staff to be in some position of authority since they are asking participants to complete certain forms, similar to a clinician when completing assessments related to participants' health, and asking questions that may be personal and intimidating.

With the increasing interest in peer-run programs nationally and within California, there is need to overcome these inherent challenges in order to develop best practices and expand funding opportunities for peer-run programs. Although there are several limitations to the current evaluation, it has demonstrated several promising techniques to increase buy-in of evaluation activities and improve the reliability of evaluation outcomes. Future evaluations can build on these techniques to better demonstrate the efficacy and strengths of peer-run programs, enabling funders and decision-makers to better justify funding for peer-run programs in the overall system of care. Peer model supervisors at LACDMH see the current evaluation approach of collecting data and analyzing outcomes as an advancement that could be applied to the rest of the peer system.

PRRCH Evaluation

Outcomes for respite programs are difficult to capture because guests leave within a designated period of time and generally do not return to the program. Nationally, a majority of peer-run respite evaluations focus on satisfaction with the respite and primarily include anecdotal evidence of the impact of respite services and success. The current evaluation attempted to use a more systematic approach by asking staff to complete assessments for all guests, asking guests to complete satisfaction surveys, and including structured qualitative components (Provider Focus Groups and the Respite Study).

Although quantitative data were collected by staff for each guest who stayed at the respites, only baseline data were collected. While this data can be used to compare guests to clients from the other INN programs, it cannot be used to determine the long-term impact of the program. Many guests (9.1%) also had multiple stays at the respite home, which may have caused differences in responses to the measures. Previous experience with the respite or exposure to the measures could affect responses. Returning guests could also differ from other guests, either by being more satisfied with the program, or by being more impaired and requiring additional care than those who do not return. Additionally, staff and guest data were completed at different points in each guest's stay. Providers noted that most guests experience the following fluctuating emotions as they stay in a respite: forming, storming, norming, and performing.[8] Staff felt that guests should not complete assessments in the early stages as they are adjusting to the new surroundings; however, they should also not complete assessments towards the end of their stay as there could be less satisfaction at the end when guests know that they will have to leave the respite soon. As staff developed a protocol for collecting guest data, they experimented with different collection time points, which may have affected responses on the Feedback Survey.

Due to the anticipated limitations of the quantitative evaluation and to address the program's overall learning goals, formal qualitative components were planned. Provider Focus Groups were conducted with staff from each program to determine their perspectives on how the program was implemented, the primary challenges, any lessons that could be applied to future programs, and the impact on guests. While these Focus Groups were informative, they only provide one perspective of the programs' impact. The Respite Study was designed to complement this data with

[8] Developed and described by Bruce Tuckman. www.mindtools.com/pages/article/newLDF_86.htm

a structured account of each respite's impact on guests from the guests' perspectives. As noted in the introduction section, the Respite Study was designed in very close collaboration with the peer providers, and guests were interviewed by peer interviewers. Both the collaborative design process and the incorporation of peer interviews are promising practices to develop evaluation buy-in and maintain the peer environment even during evaluation data collection.

Respite study participants differed from the overall PRRCH population, meaning that their experiences might not be generalizable to that population. Participation in the study was voluntary. The study intended to conduct interviews with 40 guests, 20 from each provider. Forty-five guests were interviewed near the end of their respite stay, with slightly more interviews involving guests that stayed at SHARE! (specifically, there were 21 initial Project Return interviews and 24 initial SHARE! interviews).The interviews were purposely a sample of respite guests (the 45 guests represent 7.4% of all respite guests). The evaluation budget and available time influenced the limited sample design. Looking at demographics and responses to the evaluation measures, the guests who participated in the study were more likely to be older and African American, and were more satisfied with their respite stay than guests overall. Because peer providers shared study information with all guests at the beginning of their stay, this could be due to a greater inclination to participate by satisfied guests.

Follow up was also difficult. Although the evaluation team conducted monthly outreach to interviewees with incentives for maintaining contact between the initial and follow-up interviews three to six months after their stay, some interviewees did not complete the follow-up interview after multiple forms of outreach (i.e., phone, email, and mail). Of the initial 45 Respite Study interviews, 26 guests completed the follow up interviews (57.8%). This included 12 people who stayed at Project Return's respite and 14 people who stayed at SHARE!'s respite. This attrition rate was expected due to the transitional status of many respite guests; however, it may have biased the sample towards including guests who were further along in their recovery (i.e., had a consistent phone, address, or email address to maintain contact).

Finally, trained peer interviewers conducted the interviews with PRRCH guests. As previously noted, this helped address the limitation of the evaluation potentially changing the peer respite environment. Overall, incorporating the peer interviewers had a positive impact on the study. Peer staff felt that peer interviewers would be less intimidating to guests, making them better able to gather accurate information compared to the evaluation team. Provider staff also felt that peer interviewers would maintain the desired respite environment and non-authoritative role. When reviewing transcripts, it was clear that when the peer interviewer disclosed that they were a peer, the person interviewed seemed to be open to sharing more about their personal story and experience. In addition, peer staff did not report any concerns or issues having the peer interviewers conducting interviews at the respite. However, although the peer interviewers had experience working as a peer and received training and support for their role in the study, when reviewing the interview transcripts some additional follow-up questions were not always asked even after specific encouragement and trainings. This is a common challenge for studies that involve people newer to facilitating interviewing. It may limit the information and implications that can be drawn from the data.

PRISM Evaluation

The PRISM programs relied more heavily on quantitative outcome measures to evaluate the long-term impact of the programs on participants. Staff from both PRISM programs noted many challenges to completing assessments for participants and collecting them from participants, which led to low data completion at the beginning of the programs. Trainings in data collection, the measures, and the data management system improved data collection over time; however, a majority of the data came from participants that started the program later. Additionally, data completion for follow-up assessments was low, especially for Project Return. This limits the ability to find statistically significant results and reduces the generalizability of the data to all participants.

There were also some disparities between responses to staff-completed and participant-completed assessments. Staff indicated that participants were often less honest on the forms than when they were speaking to a peer or

someone with whom they felt comfortable. Peer staff also shared that completing follow-up assessments can be uncomfortable for individuals, and can be a negative trigger of where they were. For example, completing questions about substance use during the six month assessment can be a difficult reminder of one's lowest point in their recovery.

EVALUATION LESSONS LEARNED

As with any evaluation, it was essential to have buy-in and support for the measures and the evaluation from all staff. This was a hurdle for all INN providers; however, it was especially pronounced for the peer providers as most staff had not previously participated in this type of evaluation. While there was little flexibility in the core set of measures since LACDMH wanted the evaluation to be consistent with the other INN models, the evaluation team collaborated with peer staff and LACDMH peer model supervisors to develop additional measures to capture some of the unique aspects of peer services, including linkages and referrals to help facilitate goal achievement (as reported by peer staff on the Linkage Tracker) and personal empowerment and relationship skills development (as reported by participants and guests on the Feedback Survey). The data collection system (iHOMS) was also modified to be more appropriate for use by peers. These modifications from the system used by the other INN models included developing instructional text that was culturally appropriate for individuals in peer-run programs, allowing participants to register themselves in iHOMS and initially ensuring that peer staff did not have access to participants' responses to respect the peer relationship dynamic. Incorporating peer staff feedback into the data collection system and additional measures helped improve buy-in for the evaluation. Additionally, due to the unique nature of the Peer-Run Model, the evaluation incorporated additional qualitative components, including Provider Focus Groups and the Respite Study, to better describe the structure of the programs, learning from the programs, and the experiences of participants. The evaluation team worked diligently to establish a trusting relationship with peer providers, including gaining a solid understanding of programs goals and operations.

During the Provider Focus Groups, staff noted that they see the benefit in the evaluation but had difficulties with data collection due to the nature and the frequency of the questions. Project Return staff noted that the INN evaluation information provides a helpful way for the participants to look back at where they started and what they have achieved. Peer staff were generally not comfortable completing the measures for participants. SHARE! staff felt that the act of completing measures about participants made peer staff feel like they were judging them, which is contradictory to the supportive environment and relationship they try to create. Staff also did not feel that it was appropriate to administer the self-report measures because it placed staff in more of a clinical role. Additionally, staff found some of the questions on the measures to be shaming to people or too clinically oriented. For example, one staff person noted, *"I think there are other ways of getting the information that don't involve such authoritative stance. There are peer ways of getting those questions. The research community needs to think of ways to ask those questions in a more sensitive way."* Measures are often selected for their psychometric properties and use in a wide range of populations. However, as the role of peers and peer-run programs becomes more established, it highlights the opportunity for researchers and evaluators to develop and implement more culturally appropriate and peer-friendly measures. Hopefully, use of recently developed toolkits for evaluating peer respite programs will become more widespread.

Another suggestion from a SHARE! staff member to maintain both the evaluation and participant rapport was to have these measures collected by other providers. *"Most of our people have [LACDMH Integrated System] numbers and are being seen at LACDMH. Why can't they give them the measures there?... If they are seeing them, that is the place where they are expecting to do this and they can do it there and have it track it, and in that way we are still getting the data that we need but we don't have to ruin the relationship. It is like we are ruining the product that we are providing here by having this intrusion."* This is an interesting alternative to explore. However, it may be difficult to ensure that other providers are trained in the measures and the data collection system and are able to identify Peer-Run Model participants.

Evaluation Training Recommendations

Because the evaluation of the Peer-Run Model required consistency with the other INN models, the measures for the Peer-Run Model evaluation were primarily the same measures used to evaluate the ICM, ISM and IMHT programs. The benefit of this design is that it allows for comparisons between models and populations served to provide further learning about the levels of care and needs of individuals utilizing services from INN providers. While it was a

challenge to select measures that, although appropriate for use with peer-run programs, were not specifically designed for peers, the evaluation team tested several practices to improve data completion and quality. The most effective method was increasing and adapting trainings to better share the value of the evaluation and support staff feeling more comfortable with measurement and specific evaluation activities.

Several promising practices for conducting trainings were developed:

- Peer staff should be trained separately from clinical staff as their background and familiarity with acronyms or diagnoses differ.
- All staff must be trained. This includes leadership to encourage participation and support for evaluation activities at all levels of the organization.
- Something is lost when staff train each other in the measures. Using a train-the-trainer approach is not recommended. On-site trainings were most effective because they allow more staff members to attend. Trainings should also be repeated frequently to ensure that all staff are trained. There were a lot of new hires throughout the evaluation, and it is important to get them trained soon after they are hired.
- Staff benefit more from in-person, interactive trainings compared to webinar sessions.

As the Peer-Run Model began about a year after the other Innovation models, the evaluation team had already conducted several trainings with the providers related to the data management system and the specific measures used in the evaluation. However, once the team began training peer staff, the content and structure of the trainings had to be adapted to meet their needs. This was primarily due to differences between some staff's experience with computers and data collection. Most traditional healthcare providers regularly use electronic records or computers as part of their roles, and are more likely to have prior experience reviewing and interpreting data reports with percentages and mean scores. This is not the case with all peer staff. In order to ensure that all peer staff would be able to complete and interpret data and reports, additional training was necessary. There were several lessons that seemed beneficial to the evaluation.

- It was important that trainings defined the mental and physical health terminology that is used in the measures. This included spending time to discuss and define how the traditional mental and physical health concepts assessed in the measures fit with peer staff's knowledge of recovery and their role for helping participants.
- Similarly, peer staff needed additional time within trainings to ask questions related to the function of electronic data systems. There were many unanticipated questions due to lack of familiarity with computers or the use of electronic forms.
- Training needs to emphasize how to complete measures about participants, since peer staff do not customarily "judge" or assess people's needs. For the peer staff, this training allowed them to brainstorm how to obtain information from a participant. It also emphasized that they are not being asked to place a value judgment on any of their responses, but rather are capturing a point in time so that they can better understand the participant's needs and observe improvement. Peer staff also seemed more reluctant than other providers to skip questions when they did not know an answer, so it was important to explain the use of subscales or scale scores as opposed to item-level analyses.
- Co-planning the training agenda with the peer providers helped increase openness and interest in the trainings. It was also helpful to incorporate role playing and small group discussion as part of trainings. Throughout the training, it was important to ensure that the evaluation team were using culturally appropriate terminology for peer programs. For example, the terms "clients" and "case managers" are not appropriate for peer programs. It was also necessary to consider that terms may vary among providers. For example, SHARE! preferred the term "people" while Project Return preferred the term "guests" for people that stayed at the respite.
- The peer staff also benefited from additional training in how to best discuss and use measures with participants. This was a useful technique for all INN providers, but was essential for peer staff. For many peer staff it was difficult for them to accurately describe to the participants the measures and discuss the

importance of completing them. Interactive trainings were developed to help peer staff be more comfortable with the measures themselves, and practice using peer-friendly language to share the measures with participants.

- Later in the evaluation, it became apparent that the peer staff could also benefit from training in best practices for collecting reliable and consistent data, with an emphasis on data quality over quantity. Specifically, program staff began to complete multiple follow-up assessments by phone. While this method increased the sample of matched assessments, there were issues with assessments being recreated retrospectively from memory, which impacted the reliability of the outcomes data being collected.
- Finally, all staff need to be trained on reports and data interpretation. Commonly used methods, such as statistical analyses and significance, should be defined in more practical terms. Especially for early reports, all data should be explained to ensure that peer staff understand the terminology (e.g., percentages, means, significance, etc.). Data should also be put into context, including what the data demonstrates related to an individuals' recovery.

Establishing support for evaluation activities: The greatest tool for garnering support was demonstrating outcomes through reporting. Once staff could see that their program was objectively improving health and wellness for their participants and better understand the goals of the evaluation, they were more encouraged to collect data and discussed it more positively with participants. Unfortunately, this creates a predicament, as outcome reports were not generated until midway through the project due to lack of follow up data. For future evaluations, it may help to show data from other programs using the same measures and discuss what has been found using these tools in the past. Seeing the larger picture may help peer staff understand what they are working towards.

Communication: In addition to frequent reporting, regular communication and monthly peer provider roundtables with peer staff were essential to the success of the evaluation. During peer roundtables, the providers and model supervisors shared successes and challenges, and helped each other identify solutions. Each month, SHARE! and Project Return shared success stories, and specific program changes that could help the other program, and brainstormed solutions to ongoing challenges. Members of the evaluation team also attended each roundtable to discuss data issues and to present reports. Based on these discussions, peer staff were encouraged to make program changes to better serve their participants, the evaluation team developed trainings to assist the peer staff, and LACDMH facilitated connections with resources for the providers.

Data Collection Protocol

PRISM staff discovered several unanticipated challenges related to ongoing data collection during the evaluation. Similar to the other INN models, measures were completed by or for PRISM participants every three months during their enrollment in the program. The data management system reminded staff when assessments were due for participants; however, staff found it difficult to complete them with this frequency. Overall, the programs had greater success completing staff-completed measures than participant-completed measures, especially for the follow-up assessments. Peer model supervisors at LACDMH attributed the difficulty with follow-up assessments to the challenge of retaining connections with the program participants. They reported that after 60 days, retention in the program was low. This loss of contact with participants impacted evaluation data collection, and also potentially reduced the programs' impact on participants that might have been measured with more regular or longer involvement. Peer model supervisors did not learn a solution to this issue but wanted to highlight it as a challenge of which other potential programs should be aware.

Some of the primary challenges with data collection, and the solutions developed by the peer staff are highlighted below.

- Initially, SHARE! staff scheduled appointments with participants when it was time for them to complete the evaluation assessments at SHARE!. SHARE! learned this was not very effective, as participants were not accustomed to making and keeping appointments, and often would not show up. Unlike traditional healthcare programs, participants attend program activities as desired and may not return for extended periods of time.

Staff began calling participants if they were not regularly attending the program and were due for an assessment. The staff then completed measures using a phone interview. This greatly increased completion rates, and allowed staff to maintain contact with participants. However, training in best practices for collecting quality data should include guidelines on maintaining high reliable and consistency when conducting assessments as phone interviews to ensure comparability with assessments completed in person.

- While necessary to be comparable with other INN programs, completing assessments within specific time periods was a challenge for peer participants, because participants visited the PRISM programs inconsistently and irregularly based on their individual goals. If possible, it may be beneficial to switch to completing measures every six months instead of every three months, or to use only a baseline and discharge assessment. However, it is difficult to define when discharge from the program should occur. Participants may come and go and still consider themselves part of the program despite not attending frequently enough to complete measures.
- At the request of peer staff, the evaluation team initially programmed iHOMS so peers would not have access to participant-completed forms unless they chose to share them with staff. However, peer staff shared that participants did not feel comfortable using the computer to complete assessments. Participants tended to have low computer literacy and staff reported that they were also inclined to see the process as more clinical than using paper forms. For this reasons, paper forms were made available and used by most participants, which were then entered into the data system by peer staff.

Presenting Data in Reports

Reports and feedback about program successes help motivate staff to improve data collection. Monthly and quarterly reports were shared with peer staff, with outcomes presented starting approximately half-way through the programs. Although the reports used tables and graphs to share the information, peer staff encouraged more visual presentations of the information (i.e., graphs) to help people see what wellness looks like and how outcomes change over time. Staff felt that this would help make the data more accessible and usable. After reviewing reports, staff began to use them for quality improvement, and shared them with staff and participants to demonstrate the impact of the programs. However, reports only displayed the information that was included in the evaluation measures. Staff at both SHARE! and Project Return felt it was a challenge to document progress toward goals and impact in the areas that are not captured by the currently used measures. They suggested a place where they could add comments and additional information so that the full picture and story of impact are connected to the evaluation data.

Appendix A: Background on Los Angeles County Innovation Programs

The Los Angeles County Department of Mental Health (LACDMH) is the largest mental health service system in the nation. Los Angeles County is one of the geographically largest and most diverse regions in the United States. LACDMH serves over one-quarter of a million Los Angeles County residents each year. LACDMH provides a diverse spectrum of mental health services to people of all ages, including mental health assessments, crisis intervention, case management, and medication support in both residential and outpatient settings, and is made up of a diverse workforce of psychiatrists, psychologists, social workers, medical doctors, clergy, and trained mental health consumers.

In 2004, California voters passed Proposition 63, which became the Mental Health Services Act (MHSA). MHSA aims to improve and transform the delivery of mental health services and treatment across the state of California. With funding from the California MHSA, the Los Angeles County Department of Mental Health (LACDMH) Innovation (INN) program began in 2012, and focused on identifying new and promising practices to integrate mental health, physical health, and substance use/abuse services for uninsured, homeless, and underrepresented populations. To achieve this purpose, LACDMH, in collaboration with its community stakeholders, designed four models of care to serve different underrepresented populations, and to promote community collaboration and service integration for consumers and their families.

The INN program models of care include the Integrated Clinic Model (ICM), the Integrated Mobile Health Team Model (IMHT), the Community-Designed Integrated Service Management Model (ISM), and the Integrated Peer-Run Model. The ICM, IMHT, and ISM were all launched in early 2012 in close partnership with LACDMH staff and continued through 2015. The fourth INN model, the Integrated Peer-Run Model, was implemented on a different timeline, with its programs beginning one year after the other models in 2013 and continuing through June 2016.

The goal of INN is to learn the most effective participant outreach and engagement strategies as well as integrative approaches that will improve participant health outcomes, increase consumer satisfaction, enhance service efficiency, and reduce disparities for underrepresented vulnerable populations. Unlike the other three INN models of care, the Peer-Run Model does not directly provide integrated healthcare. Peer staff serve as social support and mentors to help participants receive the holistic care they need to improve their overall health and wellbeing. Despite these differences, all four INN models share the vision of providing a fully-integrated physical health, mental health, and substance abuse treatment program for specific vulnerable populations in a large, diverse urban environment and in a complex system of care.

Appendix B: Evaluation Methods

Evaluation activities began in February 2013 simultaneously with the beginning of the Peer-Run programs. On-going trainings and discussions facilitated real-time learning and evaluation adjustments as needed. During monthly peer model roundtables, providers, LACDMH staff, and the evaluation team reviewed iHOMS data reports and reflected on the programs' challenges and learnings. Peer providers were also part of the INN learning sessions from 2013 to 2015 with the other three INN models' providers.

Data Management System

The Innovation Health Outcomes Management System (iHOMS) is a secure web-based system developed by Health Services Research Center (HSRC) as an electronic health record to track health outcomes. The system allows participants and peer staff to complete assessments electronically. Peer staff were also able to print paper versions of the assessments, which can then be entered into the system using a previous assessments mode.

iHOMS was designed to streamline the data collection and review process. Several features to improve this process include: presenting assessments as smart forms to minimize redundancy and response burden, tracking when participants are due for an assessment, a notifications system that allows for key indicators to be immediately flagged (such as suicide risk), and participant response reports available in real-time to allow participants view their recovery progress.

Another key feature of iHOMS was the integrated help functions. Many resources were available to peer staff including downloads of the training manuals, recordings of webinar trainings in using iHOMS and collecting evaluation measures, and contact information for the live help desk which was staffed during regular business hours. With such a complex system, live help proved to be invaluable to the adoption of the new system.

Quantitative Evaluation

For PRISM programs, the key indicators of overall health include physical health status improvement, mental health status improvement, substance use/abuse reduction, participant satisfaction, stigma reduction and staff linkages based on the participant's goals. Although the peer model is fundamentally different from the other INN models, the same core quantitative measures were used across each model. This ensured that the evaluation could compare outcomes of the peer-run programs to the other INN programs as well as to national norms. Quantitative measures included both participant and staff-completed measures.

To measure the PRISM participants' perspective of their behavioral and physical health and well-being, participants were asked to complete the Integrated Self-Assessment. The baseline Integrated Self-Assessment was distributed within 30 days of enrollment, and follow-up assessments were given every three months. The Integrated Self-Assessment includes the Patient Reported Outcomes Measurement Information System (PROMIS) Global Health Scale, the Creating Healthy Outcomes: Integrated Self-Assessment Supplement (CHOIS), the Physical Health and Behavior Survey, the PROMIS-Derived Substance Use Scale, and the Internalized Stigma of Mental Illness Scale (ISMI). All measures were distributed semi-annually, except for the PROMIS Global Health Scale, which was distributed quarterly. Additionally, all participants were asked to complete a Feedback Survey developed for the peer programs semi-annually.

Because PRRCH guests participation was limited to only one stay of thirty days or less, or long enough to complete one round of assessments, there was little opportunity to measure the direct impact of the PRRCH model using longitudinal quantitative methods. To help compare PRRCH guests to those from other programs, all guests were asked to report on basic physical health indicators, including height, weight, and blood pressure. Each PRRCH location had scales and blood pressure cuffs available to guests so that they could assess and report on their health. Guests also completed the Feedback Survey prior to leaving the respite.

Staff from both the PRISM and PRRCH programs were asked to complete measures to provide an additional assessment of participant and guest health and recovery. Staff were asked to complete the Illness Management and Recovery (IMR) Scale as well as the Milestones of Recovery Scale (MORS) quarterly to assess mental health and substance use recovery. Additionally, staff completed the Linkage Tracker form. The form was designed to align with SAMHSA's Eight Dimensions of Wellness. It includes the emotional, physical, environmental, social, occupational, financial, intellectual, and spiritual aspects of a person's life. These Dimensions of Wellness may help people better manage their concerns and experience recovery. This form is used to track participant goals, referrals and/or assistance provided to achieve the goals, and the success of each referral.

Assessments were completed and maintained in iHOMS described above. The system allows participants and peer staff to complete assessments electronically or to enter data from forms that were completed on paper.

Additional information on specific measures can be found in the Glossary.

Data Analysis

For PRISM outcomes, paired samples t-tests and chi-square tests were used to examine the statistical significance of changes in scores on the measures over time. These procedures provide evidence that change was due to the benefits of participating in the PRISM program and not chance variation. Statistical analysis using paired or matched samples was performed by selecting only the cases that have complete data for each time point being measured. For example, to compare change in PROMIS Global Health ratings across the first year of the program, the paired sample would only include participants who completed the PROMIS at both the baseline and twelve-month follow-up assessment.

These statistical analyses determine the likelihood that changes were due to chance, but do not demonstrate the magnitude of the change. Additional analytical techniques were used to determine applied meaningfulness, or whether the changes on the outcome measures reflect meaningful changes in individual health. Applied importance or meaningfulness is determined by individual participant improvement and is therefore less influenced by sample size.

Applied meaningfulness is determined using the Minimal Important Difference (MID), which represents the smallest improvement in a scale score that would indicate an observable change in participant health. MID estimates were calculated separately for each outcome measure using the benchmark distribution method of ½ the standard deviation of scores at baseline. Additionally, the Physical Health Indicators, such as BMI and blood pressure, as well as single-item measures of substance use, service use, and constructive behaviors use an MID of 1.

If the difference between a participant's baseline and follow-up scores on a specific outcome measure is greater than the MID, that participant is considered to have achieved an applied meaningful change for that outcome. Along with the statistical analyses, the percentage of participants who achieve an applied meaningful change is presented for each outcome measure. Additionally, for some measures, maintaining an optimal score was important when considering participant recovery over time (for example, no alcohol use). For these measures, the percentage of participants who maintained optimal scores was included with the percentage who had an applied meaningful improvement.

Qualitative Evaluation

Due to the unique nature of the peer model, the evaluation incorporated qualitative components to better describe the nature of the programs and the experience of participants. The evaluation team conducted in-person site visits with each PRISM and PRRCH provider in spring 2013. The site visit included a one to two hour conversation with program staff. During these initial site visits, the evaluation team learned more about the provider's work overall and their implementation plans for both the PRRCH and PRISM programs.

Focus Groups: To directly inform this report, the evaluation team conducted four in-person Focus Groups with PRISM and PRRCH staff from each provider in the summer of 2015. For example, one focus group was with SHARE!'s PRISM staff and one with their PRRCH staff. Each Provider Focus Group included at least three staff people. One Focus Group was also conducted on the phone with two LACDMH staff to hear their reflections about the model overall and across all programs and providers.

Respite Study: To explore short and longer-term outcomes for PRRCH guests, interviews with respite guests were designed in close partnership with the peer providers and LACDMH to learn why guests came to the respites, document their experience at the respites, and understand the respite's impact on them. Participation in these interviews was voluntary. Interviews were conducted with respite guests at both SHARE! and Project Return, and were conducted by peer interviewers.

All peer interviewers had previous experience working as a peer. After being selected from a rigorous selection process with numerous candidates, the three selected interviewers received training on the study's intention, research ethics, interviewing techniques, and the peer model. That initial series of trainings before the interviews began were conducted in partnership with the peer providers. The peer providers participated in role plays with the peer interviewers by acting as mock quests and representing real and difficult situations (i.e., combative guest) that the peer interviewer could expect. Throughout the study, peer interviews also had on-going trainings to review the interview protocols, provide feedback after listening to recordings of their interviews, and continue to provide logistical support.

After Institutional Review Board approval, the interviews began in December 2014 and continued through October 2015. Forty-five initial interviews and 26 follow-up interviews were conducted. Initial interviews were conducted toward the end of the guests' stay. Follow-up interviews were conducted three to six months after their stay was complete. Each interview lasted between thirty and sixty minutes and was conducted with the use of an eight question interview guide. Interview participants received an incentive for the initial interview, each month they remained in contact with the evaluation team, and a final incentive for the follow-up interview. Incentives totaled up to $60.

The interviews were recorded and transcribed. Content analysis was conducted to identify central themes across interviews (Milne & Oberle, 2005; Sandelowski, 2000). ATLAS.ti was used to facilitate coding and inter-rater reliability checks were used to verify coding; all disagreements among coders were resolved by consensus.

Participants in the Respite Study were compared to determine whether they differed significantly from the overall population of respite guests. There were no significant differences between Respite Study participants and all guests in substance use, overall mental health, or recovery as measured by the Illness Management and Recovery (IMR) Scale. There were significant differences in guest age and ethnicity. Participants in the Respite Study were more likely to be older than all respite guests (66.7% in the Respite Study vs. 48.0% overall), and were more likely to be African American (55.6% in the Respite Study vs. 31.4% overall). Additionally, participants in the Respite Study had significantly higher satisfaction with the program as reported on the Feedback Survey. Satisfaction was significantly greater on all but three of the sixteen items. Items on the Feedback Survey related to general program satisfaction, self-efficacy, and program impact. The different in satisfaction may be due to response bias. Participants with a more positive experience at the respite may have been more likely to agree to be interviewed. Due to time and budget constraints and the need for interviews to be voluntary, all guests could not be interviewed for this study.

Appendix C: Program Data Highlights

While both programs served different populations with different levels of needs, based on data from this evaluation, Project Return Peer Support Network and SHARE!'s PRISM and PRRCH programs help support people with their recovery. Below is a brief summary of the evaluation findings to highlight some of the positive impacts on individuals for each provider.

Project Return Peer Support Network (Project Return)

Peer-Run Respite Care Home (PRRCH)

Project Return's PRRCH program – Hacienda of Hope - is a short-term living space that provides peer support to people with mental health or substance abuse concerns. It is located in Long Beach in the Century Villages at Cabrillo. Hacienda of Hope is run entirely by people with lived experience who provide support, mentoring, and coaching. Staff see the respite as a place to build skills to help avoid future hospitalizations. To date, 310 guests have stayed at Hacienda of Hope. Guests who stayed at Hacienda of Hope were most likely to be between the ages of 48 to 59 (33.9%) and identify as White (43.9%) or African/African American (30.3%). Peer staff reported on the IMR that alcohol and/or drug use was not a factor for 70.4% of guests. The average IMR scores indicate that guests were less impacted by alcohol/drug use or further along in their substance use recovery when they enrolled in the program than with self-management and coping with their mental health and/or wellness. In general, most Project Return guests had BMIs that were normal (37.1%) or obese (33.1%). The majority of guests had pre-hypertension blood pressure (86.2%).

Project Return PRRCH Data Highlights

- Guests shared during the Respite Study interviews that the respite helped them build relationship, coping, and anger management skills through their experience staying at the respite. Guests also gained exposure to many different people during their stay. After staying at the respite, guests were able to directly apply the skills they learned and some stayed connected to the staff as a continued support network to better manage relationships and handle relapse.
- Guests also shared during the Respite Study interviews that their respite stay provided support and space so they could then begin to treat or manage physical and mental health issues.
- In general, satisfaction with the Project Return PRRCH program, as reported on the Feedback Survey, was high. Most guests agreed that they liked coming to the program, and would still come to the program if they had other choices. Most guests agreed that they felt safe at Hacienda of Hope and that there are people available to talk with as often as they felt was necessary. Guests also agreed that the program respected their cultural needs and beliefs about health and well-being.
- The majority of guests agreed on the Feedback Survey that the program helped them feel empowered to make positive changes in their life. Most guests also agreed that their mental health, physical health and substance use concerns were addressed by the Project Return PRRCH program.
- Although the PRRCH programs were initially designed to serve only guests who had a permanent address (i.e., who weren't homeless), many PRRCH guests were homeless when they entered the respite. Housing was the most common guest goal reported on the Linkage Tracker, with more than 75% of linkages to both specific housing resources and education/life skills support group on maintaining independent living were successful. Guests highlighted during the Respite Study that the respite helped them successfully link to housing and specifically to a pilot housing program with Cabrillo Gateway apartments.

Peer-Run Integrated Services Management (PRISM)

Project Return's PRISM program – Hope Well – provides participants with peer support, linkages to other community services, and financial support. Peer support varies based on the interests, needs, and goals of each participant. To date, 168 participants have enrolled in Project Return's PRISM program; participants were most likely to be between the ages of 48 to 59 (35.1%) and identify as White (34.5%) or African/African American (31.0%). Peer staff reported on the IMR that alcohol and/or drug use was not a factor for 76.6% of participants at baseline. In general, most PRISM participants had BMIs that were normal (39.2%) or obese (39.2%), and had normal or pre-hypertension blood pressure (83.8%).

Project Return PRISM Data Highlights

- Project Return PRISM participants experienced a significant improvement in time in structured roles six months after joining the program. From baseline to six months, participants with matched assessments spent significantly more time working, volunteering, being a student, being a parent, or taking care of someone else or someone else's house or apartment.
- Almost half of participants with matched assessments had an applied meaningful improvement in PROMIS Mental Health Subscale scores from baseline to six months. This suggests that participants may have experienced improvements in mental health after enrolling in the program.
- At the baseline assessment, many Project Return PRISM participants (30.2%) were homeless during the prior six months. No Project Return participants with matched assessments experienced chronic homelessness six months after enrolling in the program.
- Six months after joining PRISM, 27.3% percent of participants reduced their number of emergency room visits and 50.0% of participants maintained no hospital stays compared to baseline.
- In general, satisfaction with Project Return's PRISM program, as reported on the Feedback Survey, was high. All of the participants who completed the Feedback Survey six months after enrollment agreed that there were people available to talk with them as often as they felt was necessary, and that they participated in decision making about recovery and wellness. Most participants agreed that their mental health, physical health and substance use concerns were addressed by PRISM. Additionally, all participants who completed the survey agreed that they felt comfortable talking with peer staff about personal matters.

SHARE!

Peer-Run Respite Care Home (PRRCH)

SHARE!'s PRRCH program – the SHARE! Recovery Retreat – is described by staff as a boot camp or jump start for recovery. The Recovery Retreat serves people with mental health concerns and people who want to know more about recovery. People interviewed for the Respite Study reported that they came to the respite as a way to get away from their current situation and to focus on a healthier lifestyle, to learn new skills, and to receive support from other people. To date, 296 guests have stayed at the Recovery Retreat. Guests who stayed at the retreat were most likely to be between the ages of 48 to 59 (36.8%) and identify as African/African American (32.4%) or White (27.7%). Peer staff reported on the IMR that respite guests were experiencing more difficulty with self-management when they enrolled in the PRRCH program than with coping with their mental health and/or wellness and substance use. In general, SHARE! PRRCH guests had BMI's fairly evenly distributed between normal, overweight and obese categories. The majority of guests at SHARE! had pre-hypertension blood pressure (54.2%).

SHARE! PRRCH Data Highlights

- SHARE! PRRCH staff highlighted in the Provider Focus Group that staying at the respite had a positive impact on guests' relationships and social support. The majority of guests with a goal in the Social Dimensions of Wellness (as reported on the Linkage Tracker) were linked with self-help support groups (72.5%), and almost all of these linkages were successful (97.4%).
- Both staff interviewed and guests who participated in the Respite Study shared that the retreat built people's life skills and interpersonal skills. Guests interviewed noted that they learned specific skills as part of groups and other retreat activities, as well as through interactions with other guests, that were beneficial after leaving the respite.
- In general, satisfaction with the SHARE! PRRCH program, as reported on the Feedback Survey, was high. Most guests agreed that they liked coming to the program, and felt safe at SHARE!. Guests also agreed that the program respected their cultural needs and beliefs about health and well-being.
- Almost all SHARE! PRRCH guests agreed that they participated in decision making about recovery and wellness and that their mental health, physical health and substance use concerns were addressed by the program.

Peer-Run Integrated Services Management (PRISM)

SHARE!'s PRISM program provides full social support and connections to needed services that someone cannot typically get from a social worker or case manager. To date, 364 participants have enrolled in SHARE's PRISM program. Staff highlighted during the Provider Focus Group that participants are typically people already involved with SHARE! self-help support groups. Staff noted that the participants vary slightly for each SHARE! location, with the Downtown Los Angeles location serving more homeless people living in Skid Row than the Culver City location. While most participants were between the ages of 26 to 59, 12.9% of participants were 60 years of age or older. Participants were most likely to identify as African/African American (34.9%) or White (25.3%). SHARE! peer staff reported on the IMR at baseline that participants were experiencing more difficulty with self-management when they enrolled in the PRISM program than with coping with their mental health and/or wellness and substance use. In general, many SHARE! PRISM participants had BMIs that were normal (41.0%), but the majority of participants were overweight or obese (58.5%). Half of participants had pre-hypertension blood pressure (50.8%).

SHARE! PRISM Data Highlights

- SHARE! PRISM participants with matched assessments spent significantly more time in structured roles, such as working, volunteering, being a student, or being a parent, and also engaged in significantly more self-help activities six and twelve months after enrollment.
- Staff reported that participants made significantly more progress towards their goals and had significantly more knowledge about symptoms, treatment, coping strategies (coping methods), and medication six and twelve months after enrollment compared to baseline.
- From baseline to six and twelve months, SHARE! PRISM participants were significantly more likely to have family or friends involved in their treatment and spent significantly more time with people outside of their family six and twelve months after enrollment.
- 23.7% of participants showed an applied meaningful reduction in alcohol consumption and 17.9% showed an applied meaningful improvement in illegal drug use six months after enrollment compared to baseline. Participants had similar meaningful reductions in alcohol and illegal drug use from baseline to twelve months (22.0% and 21.7%, respectively).

- At the baseline assessment, many SHARE! PRISM participants (42.6%) were homeless during the prior six months. As reported by staff on the Linkage Tracker, 64.0% of linkages with PRRCH and 78.6% of linkages with transitional housing resources were successful. From baseline to six months, 43.8% of participants maintained no homelessness and 25.0% of participants showed an applied meaningful reduction in number of days spent homeless.
- Six months after joining PRISM, 26.0% percent of SHARE! PRISM participants reduced their number of emergency room visits and 19.2% of participants reduced their number of hospital stays compared to baseline. These reductions were also comparable from baseline to twelve months.
- Most of the participants who completed the Feedback Survey twelve months after enrollment agreed that there were people available to talk with as often as they felt was necessary and that the program helped them achieve their goals and helped empower them to make positive changes in their life.
- Twelve months after enrollment, 29.8% of participants with matched assessments gained employment, 24.6% participated in new volunteer activities and 14.3% of participants started attending school.

Glossary

Integrated Self-Assessment for PRISM: Integrated Self-Assessment is a set of self-reported core measures selected to assess the participant's perspective of their health-related quality of life, including physical functioning, quality of well-being, their physical and behavioral health, and health care utilization. Specifically, the Integrated Self-Assessment includes the PROMIS Global Health Scale, Physical Health and Behaviors Survey, Internalized Stigma of Mental Health Scale, PROMIS-Derived Substance Use Scale, and Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS).

Assessment Numbers: There are three different types of assessments: the baseline assessment, quarterly assessments, and semi-annual assessments. The baseline assessment is taken as close as possible to the participant's enrollment date and is always assessment number 1. Quarterly and semi-annual assessments are follow-up assessments that are scheduled every three (quarterly) and six (semi-annual) months after the participant's enrollment date. Follow-up quarterly and semi-annual assessments are assigned numbers in the order they are due. For example, the first quarterly assessment is assessment number 2, and the first semi-annual assessment is assessment number 3. Quarterly assessments are always even and semi-annual assessments are always odd.

Blood Pressure Categories: High blood pressure is diagnosed based on more than one criterion. The blood pressure categories provided in the report are based only on systolic and diastolic levels. The blood pressure categories for adults are the standard categories used by the American Heart Association. The categories indicate that a participant is in their provided blood pressure range, but cannot serve as a diagnosis without additional information. The blood pressure categories are as follows:

- Normal = Systolic less than 120 AND Diastolic less than 80
- Pre-Hypertension = Systolic between 120 and 139 OR Diastolic between 80 and 89
- Stage 1 Hypertension = Systolic between 140 and 159 OR Diastolic between 90 and 99
- Stage 2 Hypertension = Systolic between 160 and 179 OR Diastolic between 100 and 109
- Hypertensive Crisis = Systolic higher than 180 OR Diastolic higher than 110

Body Mass Index (BMI) Categories: Body Mass Index (BMI), which is calculated based on an individual's height and weight, is a common method of determining whether an individual is at a healthy weight. BMI categories used by the Center for Disease Control and Prevention were used to help interpret BMI values for adults. The categories indicate that a participant is in their provided obesity range, but cannot serve as a diagnosis without additional information. The BMI categories are as follows:

- Underweight = BMI score under 18.4
- Normal = BMI score between 18.5 and 24.9
- Overweight = BMI score between 25.0 and 29.9
- Obese = BMI score above 30.0

CHOIS Supplement: The Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS) Supplement was developed as a companion measure to the PROMIS mental health domains, and also incorporates recovery-based items to measure strengths. The CHOIS provides three subscale scores focusing on memory, psychosis, and strengths. All CHOIS scores range from 1 to 5. For memory and psychosis, lower scores represent less impairment (lower scores are desirable). For strengths, lower scores represent greater strengths (lower scores are desirable). Adult participants were asked to complete the CHOIS supplement every six months.

Feedback Survey: The Feedback Survey assesses adult participants' satisfaction with PRISM and/or PRRCH. Satisfaction items were combined into a score ranging from 1 to 5, with higher scores representing greater overall satisfaction (higher scores are desirable). Several of the items from the satisfaction survey were used to assess cultural competency, program integration, and engagement. PRISM participants are asked to complete the Feedback

Survey every six months (starting six months after enrollment), and PRRCH guests complete the survey during their stay at the respite care home.

Harder+Company Community Research: Harder+Company Community Research was established in 1986 with a mission to help organizations achieve social impact through quality research, strategy, and organizational development services. Harder and Company has offices throughout the state of California, and has worked with both public and private agencies to plan, evaluate and improve health, mental health, and social services programs. With a diverse and comprehensive staff, Harder+Company has the capacity and expertise to conduct program evaluation using a range of quantitative and qualitative methods in multiple languages, and has built a strong reputation for their ability to work in highly diverse communities.

Health Services Research Center (HSRC): Established in 1991 by the UCSD Department of Family and Preventative Medicine, HSRC provides comprehensive research services in the fields of health outcomes measurement, program evaluation, and informatics. HSRC strives to help healthcare organizations through innovative research, evaluation, and informatics strategies to help improve health care delivery systems and, ultimately to improve people's quality of life. HSRC comprises a diverse staff whose expertise encompasses the fields of primary care, public health, clinical and applied psychology, health outcomes measurement, program evaluation, and medical informatics.

iHOMS: iHOMS stands for the Innovation Health Outcomes Management System. The iHOMS system is built and maintained by the Health Services Research Center at UCSD as a secure, integrated electronic health record for participant outcomes. The iHOMS system was used to complete participant and staff assessments, share information between staff providing care, and bring together participant and staff information into a useable summary report.

Illness Management and Recovery (IMR): The IMR was designed as a measure of the staffs' perception of a participants' illness recovery. Items assess the extent to which the participant is participating in their treatment and achieving the goals set by their mental health provider. The IMR provides a total scale score, and three subscale scores which focus on recovery, management, and substance use. All IMR scores range from 1 to 5, with lower values representing greater illness recovery (lower scores are desirable). Staffs are asked to complete the IMR for all participants every three months.

Innovation (INN) Program: The MHSA-funded Innovation (INN) program aims to identify new mental health care practices with the primary goal of learning and exploring creative and effective approaches that can be applied to the integration of mental health, physical health and substance use services for uninsured, homeless, and underrepresented populations.

Integrated Clinic Model (ICM): The Integrated Clinic Model (ICM) is designed to improve access to quality culturally competent services for individuals with physical health, mental health and co-occurring substance abuse diagnoses by integrating care within both mental health and primary care provider sites.

Integrated Mobile Health Team (IMHT): The Integrated Mobile Health Team (IMHT) service model is designed to improve and better coordinate the quality of care for individuals with severe mental illness (SMI) or serious emotional disturbance (SED) who meet Medi-Cal medical necessity criteria for receiving specialty mental health services, were homeless or have recently moved into Permanent Supportive Housing (PSH), and have other vulnerabilities. Vulnerabilities include but are not limited to: age, years homeless, and substance abuse and/or other physical health conditions that require ongoing primary care.

Community-Designed Integrated Service Management Model (ISM): The Community-Designed Integrated Service Model (ISM) is designed to increase the quality of services, specifically for underserved ethnic communities by addressing the fragmentation inherent in the current public mental health system of care and by building on the strengths of each particular community.

Internalized Stigma of Mental Illness (ISMI): The Internalized Sigma of Mental Illness Scale (ISMI) assesses participant reported experiences with stigma and common stereotypes about mental illness, as well as the ability to resist or be unaffected by internalized stigma. ISMI items and total scale scores range from 1 to 4, with lower scores

representing decreased stigma (lower scores are desirable). ISMI scale scores are also categorized into four levels of stigma: minimal to no internalized stigma (scale scores from 1.00 to 2.00), mild internalized stigma (scale scores from 2.01 to 2.50), moderate internalized stigma (scale scores from 2.51 to 3.00), and severe internalized stigma (scale scores from 3.01 to 4.00). Adult participants are asked to complete the ISMI when entering the program, and again every six months.

Interpreting Scale Scores: Brief explanations of the different adult scales referred to in this report and how to interpret them are provided below. Besides the outcome measures, most scale scores have been re-coded so that they range from 1 to 5, with lower scores being desirable.

- IMR: The Illness Management and Recovery Scale (IMR) was designed as a measure of the staff's perception of a participant's illness recovery. Items assess the extent to which the participant is participating in their treatment and achieving the goals set by their mental health provider. The IMR provides a total scale score, and three subscale scores which focus on recovery, management, and substance use. All IMR scores range from 1 to 5, with lower values representing greater illness recovery (lower scores are desirable). The IMR is supposed to be completed by a staff at every assessment period.
- PROMIS: The PROMIS Global Health is a participant reported health-related quality of life measure that assesses multiple domains of health, including physical health, pain, fatigue, mental health, social health and overall health. The PROMIS provides a total scale score, two subscales, and a single-item pain intensity rating. The two subscales focus on physical and mental health. The total PROMIS score and the two subscales range from 1 to 5, with lower scales indicating better functioning. The pain-intensity rating ranges from 0 to 10, with higher scores indicating greater pain interference. The PROMIS is supposed to be completed by the participant at every assessment period.
- CHOIS: The CHOIS Supplement was developed as a companion measure to the PROMIS mental health domains, and also incorporates recovery-based items to measure strengths. The CHOIS provides three subscale scores focusing on memory, psychosis, and strengths. All CHOIS scores range from 1 to 5. For memory and psychosis, lower scores represent less impairment (lower scores are desirable). For strengths, lower scores represent greater strengths (lower scores are desirable). The CHOIS is supposed to be completed by the participant at the baseline assessment and at each follow-up semi-annual assessment.
- PROMIS-Derived Substance Use: The PROMIS-Derived Substance Use Scale is a participant reported measure of the negative consequences of substance use. Items ranges from 1 to 5, with lower values representing less substance use. The Substance Use Scale is supposed to be completed by the participant at the baseline assessment and at each follow-up semi-annual assessment.
- Stigma: The Internalized Stigma of Mental Illness (ISMI) Scale is used to measure participants' subjective experience with mental illness stigma. The Stigma Scale provides an overall scale score, and four categories of stigma: minimal to no internalized stigma, mild internalized stigma, moderate internalized stigma, and severe internalized stigma. Scale scores range from 1 to 4, with lower scores representing less internalized stigma. The Stigma Scale was completed by participants at the baseline assessment, and then at each follow-up semi-annual assessment. ISMI scores are also put into categories to help interpret different levels of mental health stigma, ranging from minimal to no internalized stigma to severe internalized stigma.

Learning Session: Learning sessions were designed to support the implementation of INN by creating opportunities for providers and LACDMH to identify common challenges and recognize promising and best practices as they develop in real-time.

Linkage Tracker: The Linkage Tracker was designed to align with SAMHSA's Eight Dimensions of Wellness. It includes the emotional, physical, environmental, social, occupational, financial, intellectual, and spiritual aspects of a person's life. This form is used to track participant goals, referrals or assistance provided to achieve the goals, and the success of each referral. Staffs are asked to complete the Linkage Tracker for all adult participants every three months.

Matched Samples: Matched samples are used to examine statistical changes in the outcome measures over time. A matched sample includes only the participants with completed assessments at each time point being compared.

Mental Health Services Act (MHSA): The MHSA, which was passed by California voters in 2004, aims to improve and transform the delivery of mental health services and treatment across the state of California.

Minimal Important Difference (MID): An Minimal Important Difference (MID) is the smallest change in scale or subscale scores that would be considered important by patients and/or staffs, therefore providing the smallest difference in scores that would be associated with a meaningful perceivable change. There are many ways to calculate MIDs, but for the current evaluation report, ½ standard deviation was used.

Physical Health and Behaviors Survey: The Physical Health and Behaviors Survey assesses a variety of domains, including substance and tobacco use, service utilization, constructive behaviors, and previous experiences accessing care. Adult participants are asked to complete the Physical Health and Behaviors Survey every six months.

PROMIS Global Health: The Patient-Reported Outcomes Measurement Information System (PROMIS) Global Health scale is a participant reported health-related quality of life measure that assesses multiple domains of health, including physical health, pain, fatigue, mental health, social health and overall health. The PROMIS Global Health provides a total scale score, and two subscales. The two subscale focus on physical and mental health. The total PROMIS score and the two subscales range from 1 to 5, with lower scales indicating better functioning (lower scores are desirable). Adult participants are asked to complete the PROMIS Global Health every three months.

PROMIS-Derived Substance Use: The PROMIS-Derived Substance Use Scale is a participant reported measure of the negative consequences of substance use. Items ranges from 1 to 5, with lower values representing less substance use (lower scores are desirable). Only participants who indicated on the Physical Health and Behaviors Survey that they drink alcohol and/or use drugs were asked to complete the PROMIS-Derived Substance Use Scale (participants who reported never using alcohol and/or drugs were excluded). Participants that received the PROMIS-Derived Substance Use Scale were asked to complete the survey every six months.

PRRCH Respite Study: To explore short and longer-term outcomes for PRRCH guests, interviews with respite guests were designed in close partnership with the peer providers and LACDMH to learn why participants came to the respites, document their experience at the respites, and understand the respite's impact on them. Interviews were conducted with respite guests at both SHARE! and Project Return, and were conducted by peer interviewers. Interviews were voluntary. One interview was conducted with people who agree to participate toward the end of their stay. Another interview was conducted three to six months after their stay. A separate learning brief will be issued in early 2016 with additional findings and a more in-depth analysis.