TOOLKIT FOR EVALUATING PEER RESPITES

Interviews with and surveys of peer respite programs reveal important evaluation and program design considerations.

By Laysha Ostrow and Bevin Croft
November 2014

Acknowledgements

Laysha Ostrow is president and chief executive officer of Live and Learn, Inc. Bevin Croft is a research associate at Human Services Research Institute.

Contact: Laysha at laysha@gmail.com or Bevin at bcroft@hsri.org

Contents

1. Introduction

The *Toolkit for Evaluating Peer Respites* is written for evaluators, government officials, and peer-to-peer program staff and managers. It can be used to document program operations and outcomes and to build evidence for the efficacy of peer respites. This resource includes recommendations on best practices in evaluation and data monitoring based on techniques used by other peer respites. It encompasses a range of strategies for collecting and reporting data. In this context, data is any information collected from guests who use the peer respite or people working there, regardless of whether programs use the information for research or for reporting to constituents or funders.

How the Toolkit was developed

The *Toolkit for Evaluating Peer Respites* was a collaborative effort between researchers with experience evaluating peer respites, individuals working at peer respites, and advocates who have worked at the state and national levels to inform policymakers about peer respites. The desire for a Toolkit like this emerged from the community itself.

We conducted interviews with ten peer respite directors in seven states regarding their evaluation, data monitoring, and reporting activities. Interviews were conducted in an unstructured manner over the phone; the interview guide can be found in Appendix B. We asked directors about their perspectives on the pros and cons of research/evaluation, the measures and methods they used, who is involved in designing and conducting evaluation and data collection, and how results were used.

The peer respite directors identified a variety of measures and methods. They identified concerns, many of which are common to community-based service organizations and some of which are unique to peer-to-peer support programs for people experiencing distress. The directors also cited strengths of using evaluation and data reporting. We have included direct quotes from the peer respite directors throughout this document.

Some peer respites have used data collection for quality improvement for the program itself and for reporting to funders. Others have conducted more robust self-evaluation or contracted with outside evaluators. Measures and methods that other respites have used are presented here.[1] We have also included data from a recent survey of U.S. peer respites on some of their characteristics that illustrate some important issues to consider in evaluation and program design.

Peer: A person who has experienced similar struggles and triumphs; someone with lived experience of the mental health system; a person who, through their own recovery, has gained the necessary skills to support others.

Peer Respite: An alternative to an emergency room visit or inpatient hospitalization for people experiencing psychiatric crisis; peer respites are staffed and operated by people with lived experience of the mental health system.

We used those interviews and surveys, as well as common program evaluation practices, to construct this Toolkit to be of use to new peer respites, existing programs interested in evaluation, and external (or "formal") evaluators working with peer respites.

---

[1] *Where available, we have provided reprints of measures or indicated how you may find them.*

How and why the Toolkit should be used

"If peer-delivered services want to change the mental health system, we will need to demonstrate that our methods and ways of doing things produce better outcomes than traditional services. It's not enough to measure satisfaction. Measuring satisfaction is a good place to start, but are we changing people's lives? Are people developing meaningful lives?"

The Toolkit emphasizes empowering those responsible for peer respite programs to put together the kind of evaluation they want. It provides guidance on developing a logic model and research questions, identifying outcomes, selecting measures, and using data. Evaluations should be tailored to the different program structures, values, needs, and people involved.

This Toolkit includes examples of how other peer respites have done their evaluations, options that peer respites can use for evaluation, and an ethics section explaining how to do evaluation sensitively, voluntarily, and respectfully.

There has been limited research to date on peer respites in the United States. The only randomized controlled trial of a peer respite showed improvements in self-rated mental health functioning and satisfaction for peer respite users compared to users of psychiatric hospitals (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008). Other studies are emerging in the literature, using other research methods (Bologna & Pulice, 2011; Croft, Isvan, Chow, & Peterson, 2013). There is a more substantial evidence-base for peer support and peer-run organizations (Chinman et al., 2014; Rogers et al., 2007).

There is also a moderate evidence base for acute residential crisis alternatives (Thomas & Rickwood, 2013) and other "alternative" approaches for people experiencing a first episode (Bola & Mosher, 2003; Lieberman, Dixon, & Goldman, 2013). The documented effectiveness of peer support and crisis alternatives suggests that peer respites may have the potential to minimize more costly and aversive service use for some people at some times. If peer respites are found to be associated with improved individual- and system-level outcomes, this supports the need for a greater diffusion of the peer respite model nationwide.

In the context of the traditional mental health system in which power between providers and consumers is infrequently shared, the peer respite model has the potential to create space for transformative growth—not just for peers but also for providers and policymakers.

2. Background on Peer Respites

Peer respites are voluntary, short-term residential programs designed to support individuals experiencing or at risk of experiencing a mental health crisis. They are premised on the assumption that traditional crisis services delivered in psychiatric emergency rooms and inpatient hospitals are undesirable for many mental health service users, and that the need for these services can be avoided if less coercive or intrusive supports are available in the community.

Peer respites are staffed and operated by peers with lived experience of the mental health system who have professional training in providing crisis support to build mutual, trusting relationships. Intended to provide a safe and home-like environment, peer respites are usually located in a house in a residential neighborhood.

There are 16 peer respites operating in the United States, with four more concretely planned.

Figure 1. Current and planned peer respites in the United States

Number of Peer Respite Programs 0 1 2 3
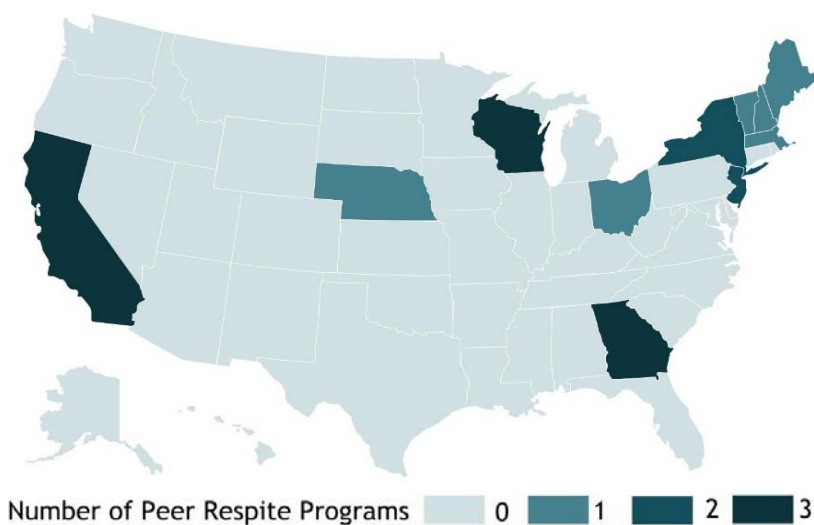
Purpose and mission of peer respite programs

Inpatient hospital beds and emergency room services are at capacity in the United States and contribute to much of the overall system cost of mental health services (Hoot & Aronsky, 2008). Peer respites may have the potential to reduce system costs while also acting as a community-based and person-centered alternative to traditional crisis services.

In many cases, local communities or funders initiate peer respites to address a need or fill gaps in available services and supports. Existing peer respites vary somewhat in their stated missions, but they share a common focus on providing a safe, supportive environment for individuals experiencing distress.

Implicitly or explicitly, most respites are intended to avert the need for psychiatric emergency services by providing an opportunity to address the underlying cause of a crisis before the need for traditional crisis services arises. Along those lines, many peer respites function as hospital diversion or "prevention" programs by serving people in "pre-crisis." These are people who are struggling with difficult emotional, psychological, or life circumstances that may be precursors to more extreme states of suicidality or psychosis. Providing a place for people to participate in a supportive community with their peers could prevent escalation of distress. These programs may also provide certain benefits to the people who work there, or have an impact on the community at large.

3

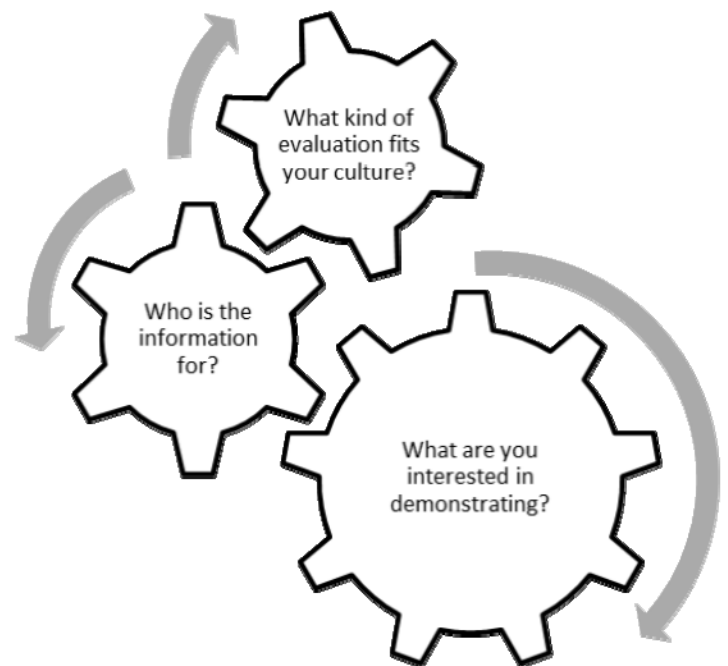## Organizational structure and types of peer respite programs

Organizational structure is critical to carrying out the program mission as many peer respites aim to effect system change. Currently, respites range from being fully peer-run and existing as separate and autonomous from the behavioral health system to peer-operated but embedded in the traditional system. Peer-run indicates that the peer respite operates as part of a larger peer-run organization that functions as an independent nonprofit and has a board of directors made up of at least 51% peers. Peers staff, operate, and oversee the respite at all levels (Ostrow & Leaf, 2014). Peer-operated indicates that though the board is not composed of a peer majority, the director and staff are peers. Programs of this type are often attached to a traditional provider or other community-based organization.

First steps

Evaluations provide information about a program's impact and potential. This information supports the community to make decisions about the program. Before embarking on an evaluation, you should first define what the peer respite is designed to do. The evaluation or data collection activities should be consistent with the program's goals for the people who use it, the people who work there, and any other people impacted by the program. Articulating the program aims is a first step to show funders or policymakers what the program is doing and how it could be improved.

There are a number of decisions that will have to be made about your evaluation or data monitoring strategy. We suggest that you think about the questions shown in the diagram below as you read this document. These questions will help inform your evaluation and data collection efforts.

What kind of evaluation fits your culture?

Who is the information for?

What are you interested in demonstrating?

3. Methods Used in Evaluation and Data Monitoring

The following are evaluation approaches and measurement tools that you may want to consider using. For the most part, these are tools that other peer respites have used either in internal data monitoring or evaluation or by external evaluators. All of the tools described here are available in the Appendix, and we've included contact information in case you wish to use or adapt them.

The evaluation plan

The evaluation plan is an important document that guides the evaluation process. Developing this plan helps you to articulate the questions you want to answer, define the outcomes you want to measure, and identify the target populations that you feel best equipped to serve.

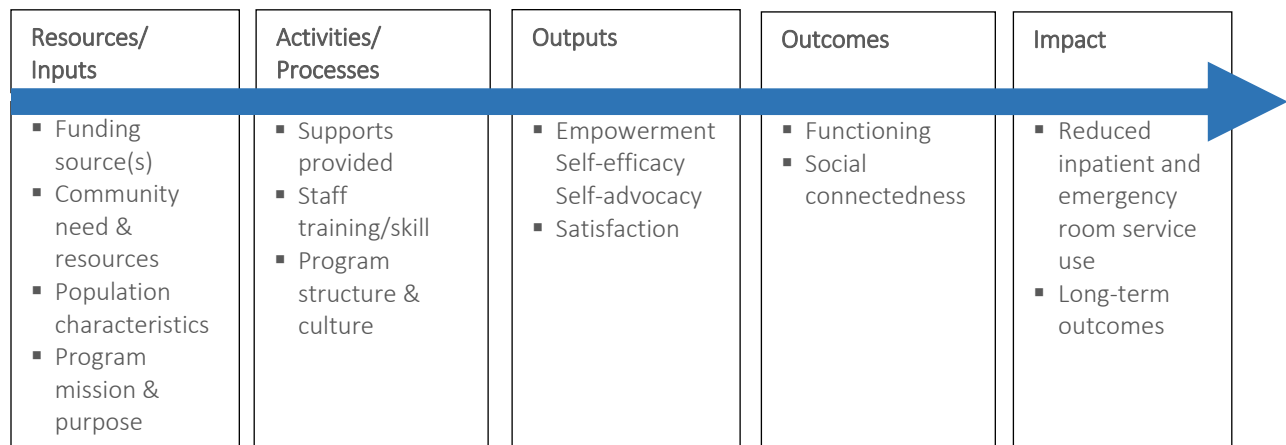## Developing a theory and creating a logic model

Exploring and identifying the process and expected outcomes of a peer respite program is an important first step in evaluation. Processes and outcomes may take place at the level of the guest, the staff, the program itself,

the mental health system, or the community as a whole. One or more of these levels may be of particular importance in the mission. The program was probably started with a particular hypothesis, even if it was not called that. For example, one hypothesis might be that if a peer respite is available, people who are in distress would use the hospital less. To determine whether the program is resulting in less hospital use, you would want data on the characteristics of the people who use the respite house, how much they use the hospital, and data on similar people who did not use the respite house.

> "I think evaluations are a valuable tool. They may give a voice to people who feel they've never had a voice before."

One important step in deciding what you want to measure or show is creating a logic model to decipher what parts of the program and its impact are important. An example logic model for a peer respite is below in Figure 2.

Figure 2. Example Logic Model to Help Decide What to Measure

Resources/ Inputs	Activities/ Processes	Outputs	Outcomes	Impact
▪ Funding source(s) ▪ Community need & resources ▪ Population characteristics ▪ Program mission & purpose	▪ Supports provided ▪ Staff training/skill ▪ Program structure & culture	▪ Empowerment Self-efficacy Self-advocacy ▪ Satisfaction	▪ Functioning ▪ Social connectedness	▪ Reduced inpatient and emergency room service use ▪ Long-term outcomes

Appendix A includes an actual logic model from a peer respite that was used in their evaluation.

The kind of data that is collected—and how it is collected and analyzed—depends on what you want to know about the peer respite and the people whose lives it impacts.

What is the question you want to answer?

All evaluations start with a question or set of questions. These questions might be open-ended or specific based on your logic model. Examples of outcomes and processes you might want to demonstrate in a peer respite evaluation include:

- What is the relationship between peer respite use and reduced emergency room and psychiatric inpatient hospitalization?
- Do people who use the respite do better in their communities in terms of using fewer services? How do they fare in terms of empowerment and self-advocacy and work and educational outcomes?
- How does the program itself work and what happens there?
- Do people like the program and feel supported there?
- Do people get connected to other supports and services that they want and that support them in their recovery?

Depending on what you want to show, you'll want to use different types of measures and reporting. Often, you'll want to use several in combination to show multiple outcomes and processes and how it is they relate.

Funders may require certain documentation to justify their support for a program. Additionally, documentation can help to sustain or grow a respite or other programs like it.

The political climate in a given state or county may determine what a respite needs to demonstrate, but policymakers frequently want to see cost savings or cost neutrality from new behavioral health programs to justify the investment over other programs that could have been selected to receive those resources. Because of the emphasis on cost in public health and social service systems, quantitative data may be required. Quantitative data include not only measures of how people are doing or what their experience is like but also data on program costs and potential cost savings. If you can collect data on how people who use the respite are doing compared to people who used other services (for example, the hospital or emergency room) and the costs for both, you can show whether the respite is a cost-effective alternative. This may be something that funders are interested in learning about your program—especially if they want to replicate it in other localities.

Who is your target population?

Peer respites differ in terms of the population they intend to serve. Some may serve people in "pre-crisis" who are having a hard time, aiming to help them avoid the circumstances that often lead to an ER visit or inpatient hospitalization. Others may specifically serve

What's a target population?

A population is a group of people who share some common characteristics. The target population for a research study is the group of people for whom you would like your results to be applied. For instance, if your study focuses on young people, your results would ideally be generalizable to all young people with similar characteristics—either personal or circumstantial.

as an "alternative" to hospitalization or diversion from the ER when people are struggling. A peer respite may target specific outreach to younger people who have never

been hospitalized, people who are not receiving any other mental health services, those experiencing homelessness or specific issues such as suicidal thoughts and feelings.

The location of a respite may also determine who uses it and why—because of other available options in the local area.

While some peer respites will serve people experiencing extreme states (for example, psychosis or mania), others cannot serve people who are actively suicidal (those who have an imminent plan or could be considered a "danger to self or others"). Respites that refuse to accept individuals in extreme states may not reach individuals who would benefit from the service; on the other hand, accepting individuals in extreme states carries significant risks that peer respites may not be equipped to manage due to the lack of funding and staff. Figure 3 shows the results of our survey of peer respites in terms of their policies toward suicidality.

Figure 3. Policies on Suicidality
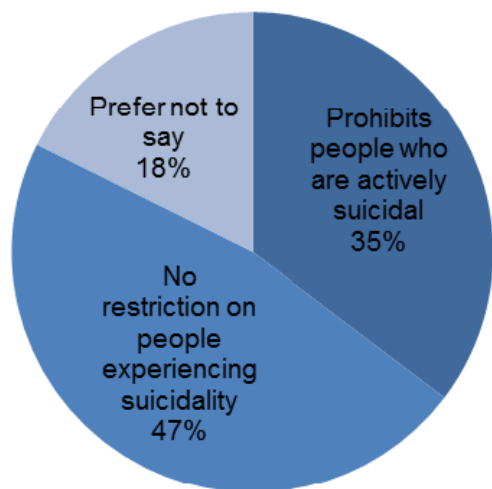
Note, some of the "prefer not to say" responses are from newer programs that have yet to state a specific policy on suicidality.

Some respites have policies in place requiring that guests have a stable housing arrangement prior to admission while others accept individuals experiencing homelessness. Refusing to accept guests without stable housing presents an ethical dilemma: many of these individuals would likely benefit from peer respite services, yet staff must eventually discharge guests "to the street" once they have reached their maximum length of stay. Peer respites that accept those without stable housing could be seen as functioning like a homeless shelter if clear policies are not in place to distinguish the respite program from a temporary housing program. Figure 4 shows the policies of existing peer respites toward people experiencing homelessness.

Figure 4. Policies on Homelessness
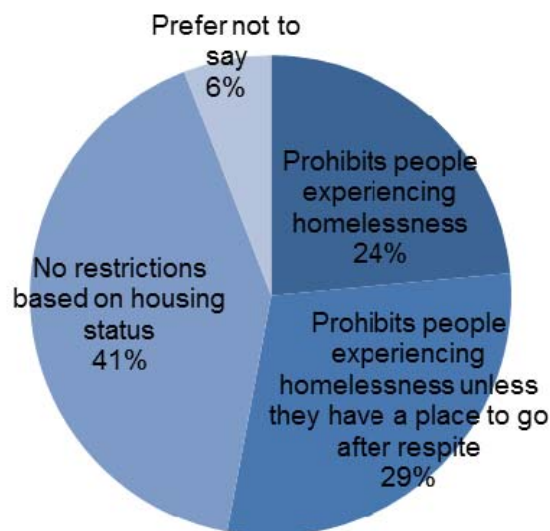
All of these things, while contributing to the program mission, also determine the target population for evaluation. These should help inform your measures and methods.

Methodological and ethical issues in research design

Research on peer respites presents a number of thorny methodological and ethical issues. These challenges are also opportunities for researchers to think differently about

evaluation approaches and discover creative and innovative methods that reflect the person-centered values of peer respites themselves.

Access to and resources for collaborators or internal expertise for formal evaluation

An important consideration is whether you have access to trained researchers, adequate funds to support a professional evaluation, and interest in doing so. Many programs can collect their own data. Each of these approaches has pros and cons.

Internal Data Monitoring
Data monitoring can be decided upon by the staff, guests, and other invested stakeholders in the program to address the evaluation questions above (for example, what you want to show and what you are required to show). Distributing surveys to guests and staff is feasible for many programs—although you should be careful about bias. Guests may not feel comfortable responding honestly to a survey if they think that program staff will be able to identify them based on their responses.

Your program may have someone on staff with formal research training who can help design and implement data collection.

Formal evaluation
For some types of funding, a formal evaluation may be required, and there may be a budget for hiring researchers. Researchers at a university or private company can be hired to help with evaluation. They will have expertise in different kinds of program evaluation and types of measurement and methods. If you are hiring researchers, they should be involved from the very start of the program so that you can be sure the program design is evaluable and that data are collected when necessary. External researchers should

be chosen based on their understanding of the program and its mission, their methodological expertise, and their ability to work with your program to have a successful evaluation and good working relationship with the guests, staff, and administrators.

Benefits & Drawbacks of Internal Data Monitoring Versus Formal Evaluation
It is important to consider the costs and benefits of data collection. More meaningful or rigorous information on the program and participants could yield a greater benefit to the community and lead to future funding opportunities, even if it requires more resources. Table 1 lists some of the comments that peer respite directors noted in their interviews regarding the potential benefits and concerns about the evaluation of peer respite programs.

Table 1. Benefits & Concerns About Evaluation and Data

Benefits	Concerns
Increased accountability to meet requirements and be used in continuous quality improvement	Data quality and potential for manipulation of results
Sustaining program funding	Demands of funders may be "clinical" and may not align with program mission
Giving people "a voice"	Replicating authority dynamics from psychiatric treatment in research approaches
Creating public relations material & legitimacy	Concerns about privacy & invasiveness
Giving feedback to community & staff	Limited financial resources for evaluation
Working toward an evidence-based practice	Standardized measures may not reflect individuality of guests

When designing an evaluation or data monitoring protocol, it is important that those organizing, collecting, and analyzing data are aware of the benefits and concerns and do as much as possible to maximize the former and offset the latter. For instance, if data are needed to sustain program funding but the funder's requirements are not aligned with the program mission, a program might attempt to reduce the measurement burden with regard to the required measurements in order to measure additional things that are better aligned with the program mission.

"The funders were clear they wanted some sort of feedback on how things were going. So we constructed a pretty basic survey that looks at comparison of experiences between the respite and more traditional services; and regardless of those comparisons, how that particular experience impacted someone in a variety of areas. That's not a particularly well-constructed or constructed-by-professional-researchers sort of effort. That was working with the funder to come up with a way to measure using people's own feedback."

When possible, it is also worthwhile to help educate funders about what is important about the peer respite to measure from the perspective of the mission and aligning measurement with the program's aims and logic model.

Some may also feel that confidentiality and privacy could be potentially violated based on the kind of data collected. It is important to secure privacy no matter what information is documented, and to ensure that people are contributing data voluntarily. Researchers have developed protocols to assure confidentiality, anonymity, and voluntary consent. We discuss these in the coming section on Ethical Issues.

Research design and comparison groups

In terms of experimental design, the use of a control or comparison group is critical to understand what would have happened to individuals had they not stayed at a peer respite. A comparison group is composed of people who *did not* use the peer respite who are as similar as possible to the group who *used* the peer respite. By comparing the respite users to the comparison group, you can attribute the difference in outcomes to use of the peer respite. While purely observational methods such as asking guests "What would you have done if the peer respite was not available?" are easy to implement, they are subject to biases in reporting and recall. A randomized control trial remains the gold standard for ensuring that those who did and did not use the program are comparable to one another; however, when practical and ethical considerations make a randomized design infeasible or unacceptable to program participants, other quasi-experimental methods may be employed (Croft et al., 2013). These may include propensity score matching or wait-list control designs.

Evaluations may also benefit from understanding the dose-response effect. This refers to how much an intervention (the dose) impacts the outcomes (the effect). For peer respites, the "dose" would be the number of days spent at the peer respite or some other variable that measures the intensity involvement with the program.

The timing of an evaluation is also important. Longitudinal designs involve collecting information from participants multiple times over the course of a study. For example, a study that collects information from former guests will help to understand if the program has a long-term impact.

Decisions about target population also have an important bearing on research design. In some programs, eligibility criteria are very minimal. These programs may work with large numbers of people who do not use other mental health services. In this case, it will not be possible to use administrative data on mental health service use or to examine the peer respite compared to respite users' experiences of other mental health services.

Attitudes toward research

Community attitudes toward evaluation and data collection should be taken into account when developing an evaluation for a peer respite program. Evaluations and data collection techniques must be sensitive to program and participant values and the potential time and energy burden on guests and staff. If data are to be collected, they should be as robust as possible to inform ongoing program and community needs and resources, as well as helping others start or sustain peer respites. There is a whole spectrum of perspectives on what is important and why. You do not have to be committed to traditional or formal evaluation in order to be able to report something that is meaningful.

Some people who participate in peer respites—as staff, managers, guests, or other community members—do not wish to impose

"I think that typical sort of mainstream programs really are aimed toward becoming evidence-based practices. We don't have that same focus. I think it's in part because a lot of the general practices of research get in the way of connection and make people really nervous. People have felt victimized by a lot of research. They've felt taken advantage of. It's warped the focus of a lot of relationships."

a burden on the program by collecting data or information. The amount and type of information collected should consider program and participant burden, including voluntariness for participants and at program level; moreover, researchers should be wary of placing a burden on staff whose efforts should be focused on working to support the program mission.

Ethical issues

Because peer respites are small programs targeted to individuals experiencing distress, researchers must be carefully attuned to the possibility that primary data collection may be experienced as intrusive or present an undue burden to respite guests and staff. Just as the peer staff at respites work to ensure that their practices are reflective of the program mission, researchers too should ensure that their activities are in concordance with the ethos of mutuality and shared power. This may be accomplished by employing the participatory research methods discussed below and ensuring that feedback from the community, including peer staff and guests, informs the research at all stages—from research design to interpretation to the dissemination of results. This approach may pose a challenge if the priorities of research funders and the standards of science are at odds with those of the community.

Stakeholder involvement and engagement: Community-based participatory approaches

As stated in Seekins & White (2013), many people who engage in research are interested in "the extent to which those expected to use or benefit from research products judge them as useful and actually use them" (p. S20). It is essential that when people participate in research—as investigators, program administrators, or service users—that what is produced is meaningful in decision-making.

It is important to recognize the difference between more inclusive participatory models of research and research that simply includes people with lived experience in an advisory capacity. Participatory research not only includes the educated elite within a given minority group but also pursues research questions identified and developed by the target population (Minkler & Wallerstein, 2010). It should be done in a way that is collaborative and actionable, establishes structures for participation, and includes organizational representatives and trained researchers who identify with the community (Viswanathan et al., 2004). This kind of research can lead to:

- Greater participation rates in research by harder-to-reach populations
- Increased external validity
- Decreased loss to follow-up

Additionally, this type of research can increase individual and community capacity because community members begin to see the long-term gains associated with research, in comparison to serving as participants in data collection or as passive recipients of dissemination efforts (Viswanathan et al., 2004).

With community member participation at all stages, along with research led by consumer-researchers, the researchers tend to be viewed not as disinterested outsiders but as allies actively working to meet the community's perceived needs (Meleis, 1996).

"I'm just cynical enough to believe that it's garbage-in-garbage-out so you have to be real careful with data as you don't know where the data is coming from. But that being said we need to be tracking. We're a real world service. We're as legitimate as any other mental health service. We have to be able to show that it's accomplishing things."

A participatory research framework means including all relevant stakeholders in identifying outcome measures, conducting research, using results. For peer respites, stakeholders may be people in the community who may use the peer respite to promote their own wellbeing or avoid other services, community activists working to change mental health systems, people who work or volunteer in the peer respite, and funders who may want to see certain results demonstrated.

Data collection & analysis

How and why data are collected and analyzed is an important topic in research and evaluation. While it might seem relatively easy to collect any data you *may* want, it is important to use data collection efficiently and consistently with your analysis plan to reduce burden on participants and to contain the costs of the project. This is particularly important in a context where research participants might be feeling vulnerable and need to focus on themselves and relationships.

Types of data

A mix of quantitative and qualitative methods are appropriate for studying complex behavioral health interventions such as peer respites (Creswell, Klassen, Plano Clark, & Smith, 2011; Wallerstein & Duran, 2008). Qualitative approaches such as in-depth interviews enable researchers to explore complex relationships between respite use and outcomes that may not be apparent through the analysis of cost, service use, and survey data alone. The infusion of qualitative approaches is particularly warranted because of peer respites' emphasis on self-defined outcomes and their need to understand guest perception of services and the perceived relationship between the peer respite and other traditional crisis services. In addition, because research on peer respites is in its

infancy, qualitative approaches may begin to help us understand what should be measured.

Qualitative data can be very useful in documenting whether the peer respite is operating within the mission and experienced that way by the guests. In open-ended interviews, guests can be asked about their experience during their visit to the respite house. They can also be asked to describe what they found helpful or not helpful. Open-ended interviews can also help us understand

> "It's all voluntary, so people don't wanna push anybody. The staff makes connections, very human connections with people. So, we have very few problems with some of the same problems that might occur in a hospital setting or a professional setting…we don't come from the place of authority or knowing or telling or any of that. We get a much a much more relaxed, trusting connection where people are more comfortable to share what's going on in their lives."

what the experience of "crisis" (or "pre-crisis") is like when they come to the peer respite and after they leave. Many peer respites use satisfaction surveys with guests during or after their stay to document what they did and did not like about the peer respite. These data are then used in internal quality improvement processes.

Because peer respites differ in their implementation, formative process evaluations should accompany any exploration of outcomes. Formative process evaluations document challenges and lessons learned and explore program design issues (Fixsen, Blase, Naoom, & Wallace, 2009). This information is fed back to the program throughout the evaluation process (not just at the end of the evaluation) to support continuous growth and improvement.

Implementation and fidelity

Organizational structures and processes of peer-run programs that improve outcomes such as empowerment and stigma reduction also have the added value of employing peers in positions of prestige and control (Segal, Silverman, & Temkin, 2013). The values of mutuality and equality in peer support may be even more important in crisis support when people are feeling vulnerable and/or unstable.

Because of hierarchical power dynamics in traditional mental health treatment, peer respite programs must be intentional in how they interface with the rest of the behavioral health system.

Implementation and Fidelity Measurement Tools

The **Fidelity Assessment/Common Ingredients Tool (FACIT)** is used to evaluate fidelity to the consumer-operated/peer-run model that includes 46 items on the domains of Structure, Environment, Belief Systems, Peer Support, Education, and Advocacy (Johnsen, Teague, & Campbell, 2006). It was revised to reflect the mission and ethos of peer respites and Intentional Peer Support in 2011 by the evaluators of the 2nd Story Program, and that version of the instrument is included in the appendix of this Toolkit.

Intentional Peer Support (IPS) is a trauma-informed, peer-delivered training and supervision model that is used in many peer respites. Based on a detailed training program developed by peers, Intentional Peer Support uses reciprocal relationships to redefine help, with a goal of building community-oriented supports rather than creating formal service relationships (Mead, 2011).

Understanding and responding to conflict is a key element in the IPS model, as is negotiating and sharing power between and among peer staff and guests. Within the IPS framework, peer staff and guests negotiate ways of acting and work to resolve interpersonal issues and understand and negotiate their own intense experiences through a dialogic process to transform meaning for all parties.

This approach stands in stark contrast to traditional forms of behavioral health delivery. Rather than reverting to the typical imbalance of power in the traditional mental health treatment relationship in which the provider delivers a prescription for mental health to the service user, the IPS relationship involves a leveling of the field and an open discussion, without the presumption that the provider has any more expertise than the "consumer."

Along these lines, measuring processes of care and interactions with guests in terms of reducing iatrogenic harm while increasing service-user choice and mutuality of relationships within the program (management, staff, and guests) are essential for defining fidelity to the model. Measures of the program culture, coercion and hierarchy, and an environment that promotes recovery and human rights are important to consider when evaluating peer respites. Many peer respites use satisfaction measures in their evaluations, which contribute to our knowledgebase on the environment and guests' perceptions of it.

Process Measurement Tools

Staff Level Measures: IPS Core Competencies
IPS emphasizes the development of a set of Core Competencies that emphasize informal, reciprocal relationships between staff and guests as part of the service delivery. A team of evaluators has worked with the developers of IPS to create a Core Competencies scoring system for guests and staff, and a version of that tool is included in Appendix A.

Satisfaction and guest surveys of experience
Many peer respites have developed their own measures of guest satisfaction and experience of their stay. We have included self-developed and implemented measures from Afiya, the Georgia Peer Support and Wellness Centers, and 2nd Story in Appendix A. Rose House also worked with evaluators to develop a survey for guests (also available in Appendix A).

Qualitative interviews of guests, staff, and other stakeholders: 2nd Story
Speaking with key stakeholders is integral to understanding the process of developing and implementing a peer respite. These key stakeholders can include guests, program directors and staff, peer advocates, mental health providers and administrators, funders, neighbors, and others. Interviews with stakeholders need not be highly structured, but they should provide opportunities for stakeholders to voice what they see as the most important dynamics or elements of the peer respite. It can be useful to prepare key questions in advance in the form of semi-structured interview guides. These guides can be tailored based on an individual stakeholder's particular interests or expertise. Copies of the interview guides used in the 2nd Story evaluation are included in Appendix A.

Outcomes

Peer respites' goals are wide-ranging and include reducing emergency hospitalizations for psychiatric crises, fostering recovery and wellness at the individual level, reducing overall service system costs, and increasing meaningful choices for recovery at the level of the service system.

Peer support rests on the principle that wellness is self-defined by the individual guest. Thus by definition, peer respites' success in promoting recovery and wellness

"It's definitely a challenge to find the right tool and still honor the individual. Recovery is not linear and you can go back and forth. You can be doing great for five years and then one blip…does that mean you have to start from scratch? How do we really measure it?"

can be measured in terms of the extent to which they support individual needs and preferences. Staff members engage with one another and with the guests to discover what works best and then provide for or connect the guest with those supports. It is hoped and hypothesized that the availability of alternative supports for recovery will reduce the need for acute psychiatric services and in turn reduce the overall costs of mental health services to the county. Through the peer support model, all staff members are committed to the notion that creating and maintaining mutual and supportive peer relationships are the primary goal, while reducing costs and the need for acute care are secondary.

Although many individual-level outcomes are inherently self-defined, a number of individual-level domains may capture the peer respite's impact. These include measures such as quality of life, housing stability, and the development of social relationships and natural supports. These outcomes may be expected to change immediately after a respite stay.

Although the peer respite's focus is explicitly non-clinical, it is possible that there may be measurable improvements in clinical domains such as mental-health related functioning and symptom severity. In the

long-term, recovery domains such as employment, education, community and civic engagement are worth exploring, and there are many measures available to address those domains (Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005).

"What works at one respite center is not going to work at all of them. Economics plays a role, your location plays a role, even what part of the country you're in plays a big role in how your respite should or shouldn't be operated. I don't think they're all on the same page yet to understand that just because we do things one way here does not mean you have to do it that way. This is just what works for us."

Outcome Measurement Tools

The tools described below are currently used in peer respite evaluations.

Recovery measures: Recovery Markers Questionnaire (RMQ) and Mental Health Recovery Measure (MHRM)

The RMQ and MHRM are measures of individual recovery. The RMQ is the freestanding individual-level subscale of the Recovery Enhancing Environment measure (REE). REE has a total of 166 items, which are organized into eight domains: Demographics, Stage of Recovery, Importance Ratings on Elements of Recovery, Program Performance Indicators, Special Needs, Organizational Climate, Recovery Markers, and Consumer Feedback. The MHRM contains 30 items in seven domains: Overcoming Stuckness, Self-Empowerment, Learning and Self-Redefinition, Basic Functioning, Overall Well-Being, New Potentials, and Advocacy/Enrichment. These and other measures of recovery are available at: www.hsri.org/publication/measuring-the-promise-a-compendium-of-recovery-measures-volume-ii/

Traditional measures of functioning and distress: Level of Care Utilization Survey (LOCUS)

The LOCUS is typically used for providers to rate clients. However, it has been adapted in some places for self-rating. The six evaluation parameters include: (1) risk of harm; (2) functional status; (3) medical, addictive and psychiatric co-morbidity; (4) recovery environment; (5) treatment and recovery history; and (6) engagement and recovery status. A five-point scale is constructed for each. The LOCUS tool is available on the American Association of Community Psychiatrists website at: www.communitypsychiatry.org/pages.aspx? [PageName=Level_of_Care_Utilization_System_](www.communitypsychiatry.org/pages.aspx?) [for_Psychiatric_and_Addiction_Services](www.communitypsychiatry.org/pages.aspx?)

Service utilization & cost

Because of the complex processes around deciding whether to use the peer respite or other acute or emergency services, it is inaccurate to compare the cost of a peer respite day to the cost of a hospital day in a budget or billing statement. There are also other factors to consider. For example, people may use peer respites differently than they use other crisis services, and they may use a combination of peer respite services and other inpatient or emergency services depending on their situation.

In cost-effectiveness research, programs are recommended based on the ratio of cost and effects or outcomes—not just cost alone (Table 2). When examining the costs associated with peer respites, it is important to remember that a program need not save money to be effective. If it leads to improved outcomes for individuals but costs the same or even slightly more than traditional inpatient or emergency services, there may still be a case for implementing the program.

Table 2: Decision Rules for Cost-Effectiveness

Effects	Costs	
	Positive	**Negative**
Positive	Case 1: Select program with lowest ratio (for improving health)	Case 2: Program should generally be implemented
Negative	Case 3: Program should generally not be implemented	Case 4: Select program with highest ratio (for reducing costs)

Some Possible Impacts on Cost

If a peer respite is acting as a preventive intervention to avert the escalation of a mental health crisis, one would expect peer respites to be associated with some reduced system costs through a decrease in the use of costly inpatient and emergency psychiatric services.

The relationship between peer respite use and other community-based mental health service use is unclear right now. It is possible that by helping guests attain greater stability and self-determination, peer respites will result in some guests becoming *more engaged* with behavioral health services and supports, which could translate to *increased utilization of some services* in the short term. For this reason, cost and service utilization analyses should be linked with data on other individual-level outcomes when possible—although this partly depends on the program's requirements for whom they will serve (that is, whether those people need to be public mental health clients with other available data).

Challenges Accessing and Analyzing Cost and Service Utilization Data

Understanding the costs and utilization for mental health services requires a detailed examination of system-level data. Because inpatient and emergency services are financed through multiple means (for example, Medicaid, state, and county general revenue), accurate estimates of cost may not be available in a central administrative database. If you can merge these data sources, you can estimate how much of other services people are utilizing. This can approximate the cost of using the peer respite and other services.

Using Program Data and Other Data

If you would like to estimate whether peer respites impact how people use other services, you may want to consider methods such as analysis of administrative datasets and non-randomized designs. More sophisticated regression analysis methods may have to be used to see significant differences, and we highly recommend that peer respite programs work with a statistician. The approach described here is to better inform readers about what a cost or utilization study might require.

To do analyses on cost and utilization, you would need complete data on other service utilization for people who used the peer respite and similar people who did not (a comparison group). Then you would "match" people to other individuals who are similar to them on the variables that you have. Suggestions on variables you may need and that would be available in most administrative datasets are listed in Table 3 on the following page.

Table 3. Variables Used to "Match" Similar People

Variable	People who *used* the peer respite	People who *did not use* the peer respite
Peer respite utilization		
Number of respite stays		
Days spent in respite		
Demographic characteristics		
Age, years		
Gender		
Race		
Ethnicity		
Education, years		
Marital status		
Clinical characteristics		
Global Assessment of Functioning score		
Psychiatric diagnosis		
Substance use diagnosis		
Service use history		
Emergency or inpatient services		
Outpatient services		
Substance use services		
Legal status (voluntary or involuntary)		
Has a care coordinator/case manager		
Living in board and care		
Homeless		

**Note: This table is empty because it is an example of data you may need.

You would want the people in the "used the peer respite" and "did not use the peer respite" columns to be the same on all of these variables *except* for whether and how much they stayed at the peer respite. If they are the same in all of the other variables, it indicates that you could attribute any differences in the outcome variables to the use of the respite.

Table 4 is an example of the outcomes you might want to see—in this case use of emergency or inpatient psychiatric services.

Table 4. Outcome Variables for Cost Analyses

Outcome Variables	People who *used* the peer respite	People who *did not use* the peer respite
Inpatient & Emergency Services Use		
Used inpatient/emergency services at all	Yes/No	Yes/No
Total days (or hours) of inpatient/emergency services use	Number of days/hours	Number of days/hours

Doing an analysis like this helps you determine if people who use the peer respite are more or less likely to use more or less inpatient or emergency services after a respite stay. From there, if you know how much all of these services cost, you can estimate the total cost.

Recommendations on cost analyses: Specialized research

Cost and cost-effectiveness research and analysis is a specialized type of research if you want to account for things like other service utilization, capacity or "census," fixed and variable costs, and other available organizational supports that may impact the overall cost (and effectiveness) of the program. If you want to demonstrate costs and outcomes in this kind of relationship, it is advisable that you consult with someone skilled at economic analysis or complex statistical models of community and health service systems.

Considering Occupancy in Estimating Program Cost

One of the issues with cost-effectiveness research on peer respites—and a consideration in these programs' long-term funding sustainability—is the "census" they keep. If the program is not at adequate capacity most of the time, the fixed costs outweigh the variable costs, thereby limiting the program's value to the community or funder. Figure 5 shows the average census of peer respites across the United States. On average, peer respite houses were about 50% full, with a range between 29% and 82%.

Figure 5. Average Peer Respite Census
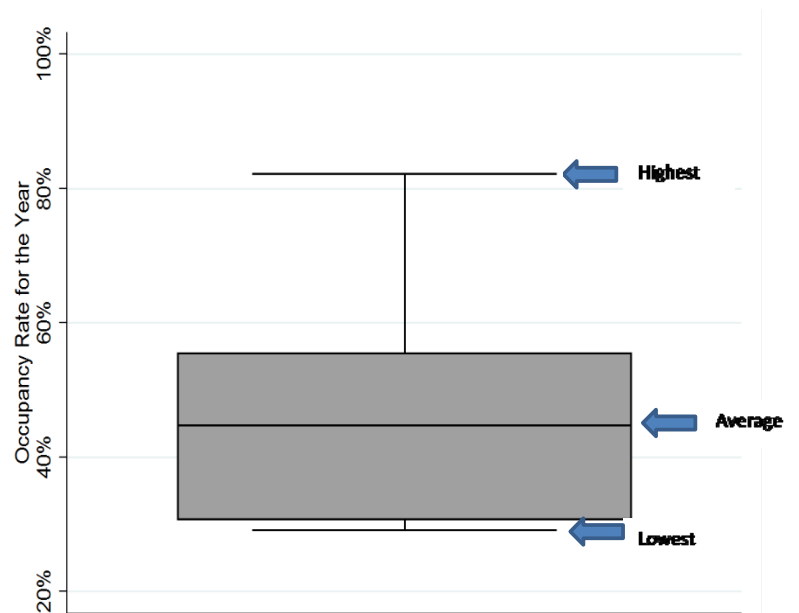
Measuring census and finding ways to keep the program at capacity through referrals and outreach contributes to defining the costs. Additionally, if the peer respite is linked to a larger organization or is serving people in other ways than overnight stays (for example, as a "drop-in" center or including a warmline), those costs and the people served should be taken into account when analyzing the cost and value of the program.

4. Dissemination

The reasons you are conducting an evaluation or monitoring data may be related to external requirements, to internal quality improvement, or to a contribution to the scientific literature.

What does your funder or oversight agency require?

Peer respites in the United States are commonly funded by county or state dollars. In some cases, certain programs receive federal or private funding. Figure 6 shows the sources of funding for the peer respite programs we surveyed this summer.

Figure 6. Funding Sources for Peer Respites
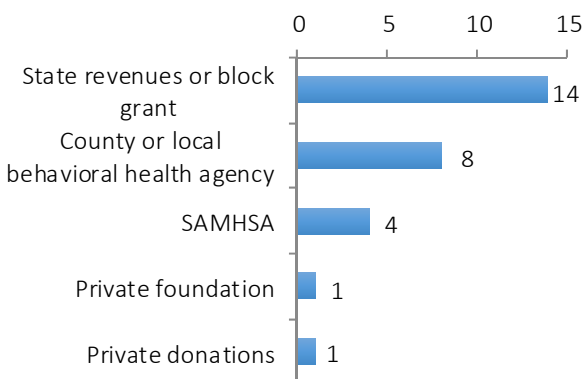
Note, many programs report more than one funding source

Your funder or another oversight agency (a fiscal intermediary, government agency, or health insurance network) may require that you collect and report certain data.

How results will be used

There are many options for using the results of your evaluation or data collection. You may want to report back to the participants, staff, and community members. It may be important to you to publish papers in peer-reviewed journals or to report to a larger stakeholder base (local or national advocates). The program funder may require that you have an evaluation. You may want to contribute to building an evidence base for peer respites. What you want to show and to whom will determine in part the types of data you collect. These considerations will also influence your plans for dissemination.

However you decide to disseminate your results, it is important that you make them available in multiple formats so they are accessible to a variety of stakeholders— funders, peers, advocates, providers, participants, and the general public. Producing materials in multiple formats increases the impact of your evaluation work and ensures that all who contributed to the evaluation process are able to see the results.

When possible, consider involving key stakeholders in the dissemination process throughout the evaluation. This may involve feeding preliminary results back to program staff, participants, local advocates, or others who have an interest in the peer respite program. These individuals may act as a panel of key informants who can review your work and comment on whether your interpretation of the results seems plausible. Additionally, they can help identify things you may have overlooked or lend insights to complex findings. In preparing your final results, consider building in time for stakeholder review to ensure that you are characterizing the program and its impact appropriately.

5. Future Directions in Peer Respite Research

Research is clearly needed on peer respites as they expand in number and diversity. While these programs may vary in their interest in research and their ability to conduct it (either internally or in partnership with outside evaluators), it is critical that the research community engage this small but growing population in some form of standardized evaluation. Not only can research aid in continuous quality improvement and program modification, it can also assist funders in understanding the benefits and costs. Moreover, it can help build an evidence-base from which to compare peer respites and generalize knowledge to new and existing programs.

By working to change the culture of the traditional mental health system through the presence of alternative paradigms for service delivery with peers in leadership and practitioner roles, peer respites serve as a peer-to-peer resource. In addition to providing support for those in crisis or pre-crisis, peer respites act as dynamic community spaces where peers can volunteer, connect, and seek and receive informal supports. Because peer respites are often a program of a larger peer-run organization, they may enhance the availability of an array of mutual support or self-help resources in the community—such as Wellness Recovery Action Plans (WRAP), suicide or hearing voices support groups, and wellness-oriented activities (Ostrow & Hayes, 2013).

One thing that was very clear in our interviews with peer respite directors was the great amount of passion and energy behind sustaining these programs and serving their communities. Some expressed the need for standardized and uniform measurement across peer respites in order to

establish an evidence base or "evidence-based practice." However, there were also concerns expressed about how "evidence" is determined and by whom; for example, how it may or may not reflect the individual nature of crisis and recovery. Collaboration with peer respites and their specific stakeholders will be essential in defining the evidence-base across sites and in establishing best practices that also work locally. Fidelity measurement (defining what the program actually does and how) will also be important to compare peer respites and say they are all doing similar things that allow us to say the mechanism of action is the same.

An important consideration in building a uniform evidence-base is that these are very small programs that, by design, can only serve a few people at a time. This limits the statistical power (that is, the inferences one can draw from the data given a small sample size). If the data collected were uniform across peer respites, we would have larger samples to draw more powerful conclusions.

The organizational features of respites have critical implications for their financing and sustainability. Peer-operated services attached to traditional provider organizations may have greater access to financial resources and program infrastructure, including IT resources and the capacity for third-party billing. However, local peer-run organizations may prove more effective in the long run. In either case, careful consideration is needed to align financing with program mission, including understanding the feasibility of using Medicaid funding, which can be used to cover peer support services in some states (Ostrow & Leaf, 2014).

With a growing evidence-base and definition of really "doing peer respite," it will be easier

for other localities to make an argument for funding these programs in their states and counties. It would also likely provide financial security for existing peer respites to maintain funding given the choices local health systems and other payers must make in investing in recovery-oriented, person-centered supports for people in distress.

Appendix A: Measures and Tools Used by Peer Respites

Fidelity & Processes

Fidelity Assessment of Common Ingredients Tool (FACIT)

2nd Story Peer-run Respite Version – Human Services Research Institute – Revised December 2011

Date: _____   Method of Administration: _____

Ingredient	Definition	Anchored Scale	Score	Notes
1. STRUCTURE **1.1. Consumer Operated**				
1.1.1. Board Participation	Consumers constitute the majority (at least 51%) of the board or group that decides all policies and procedures.	1) No member of the board is self-identified as a consumer; 2) 1-50% of the board is self-identified as consumers; 3) 51% of the board is self-identified as consumers but less than 51% of the officers are self-identified as consumers; 4) 51% or more of the board are self-identified as consumers and more than 51% of the officers are self- identified as consumers; 5) 90-100% of the board is self-identified as consumers and all of the officers are self-identified as consumers.		
1.1.2. Consumer Staff	With limited exception, staff consists of consumers who are hired by and operate the Program.	1) No staff member of the staff identifies him/herself as a consumer; 2) 1-50% of staff members identify themselves as consumers; 3) 51% or more of the staff identify themselves as consumers but less than 51% of administration identify themselves as consumers; 4) 51% or more of the staff identify themselves as consumers and more than 51% of administration identify themselves as consumers; 5) 80-100% of staff identifies themselves as consumers and all of the administration identifies themselves as consumers.		
1.1.3. Hiring Decisions		1) Consumers are not involved in any hiring decisions; 2) Consumers have some involvement in hiring decisions; 3) Consumers are responsible for making most of the hiring decisions (50% or more); 4) Consumers are responsible for making all hiring decisions.		

22

Ingredient	Definition	Anchored Scale	Score	Notes
1.1.4. Budget Control	Consumers have control of the operating budget	1) Consumers are not involved in the development or control of the budget; 2) Consumers have some involvement in the development and control of the budget; 3) Consumers are responsible for the development and control of most of the budget; 4) Consumers are responsible for the development and control of the entire budget.		
1.1.5. Volunteer Opportunities	Role opportunities for participants may include board and leadership positions, volunteer jobs and paid positions.	1) No consumers are volunteers; 2) 1-24% of the volunteers are self-identified as consumers; 3) 25-49% of the volunteers are self-identified as consumers; 4) 50-74% of the volunteers are self-identified as consumers; 5) 75-100% of the volunteers are self-identified as consumers.		
1.2.1. Planning Input	The program responds flexibly to the needs of participants.	1) There are no realistic opportunities for consumer input; 2) There are some opportunities for consumer input but the program does not display a commitment to implementing recommended changes; 3) There are some opportunities for consumer input but the program displays minimal commitment to implementing recommended changes; 4) There are many opportunities for consumer input and the program displays a commitment to implementing recommended changes; 5) There are multiple avenues evident for providing input and the program displays a significant commitment to implementing recommended changes.		
1.2.2. Satisfaction/ Grievance Response	Consumers have ways to indicate dissatisfaction with their program and to have grievances addressed.	1) There are no realistic opportunities to express grievances or dissatisfaction with the program; 2) There are some opportunities to express grievances or dissatisfaction with the program but the program does not display a commitment to implementing necessary changes; 3) There are some opportunities to express grievances or dissatisfaction with the program but the program displays minimal commitment to implementing necessary changes; 4) There are many opportunities to express grievances or dissatisfaction with the program and the program displays a commitment to implementing necessary changes; 5) The program has a formal policy for addressing grievances and for assessing consumer satisfaction and displays a significant commitment to implementing recommended changes.		

Ingredient	Definition	Anchored Scale	Score	Notes
1.3.1. Linkage with Traditional Mental Health Services		1) There is no reported substantial linkage to traditional mental health services; 2) There is report of minimal involvement with traditional mental health services; 3) There is report of moderate involvement with traditional mental health services; 4) There is report of intense involvement with traditional mental health services but this involvement is not reciprocated; 5) There is report of intense involvement with traditional mental health services and this involvement is reciprocated.		
1.3.2. Linkage with other consumer-operated service programs (COSPs)		1) There is no reported substantial linkage to COSPs; 2) There is report of minimal involvement to COSPs; 3) There is report of moderate involvement to COSPs; 4) There is report of intense involvement to COSPs but this involvement is not reciprocated; 5) There is report of intense involvement to COSPs and this involvement is reciprocated.		
1.3.3. Linkage with other service agencies		1) There is no reported substantial linkage with other service agencies; 2) There is report of minimal involvement with other service agencies; 3) There is report of moderate involvement with other service agencies; 4) There is report of intense involvement with other service agencies but this involvement is not reciprocated; 5) There is report of intense involvement with other service agencies and this involvement is reciprocated.		
2.1.1. Local Proximity	Consumers can walk to the program or get there by public transportation; or the program comes to the consumer	1) The program is physically remote from any population cluster; 2) The location of the program is close to but not in a population cluster; 3) The location of the program is within a population cluster, but with minor improvements possible; 4) The location of the program is optimal – at the very center of a population cluster. It is difficult to conceive of further improvements.		

Ingredient	Definition	Anchored Scale	Score	Notes
2.1.2. Access		1) Speed and convenience in terms of: proximity to means and routes of access, variety of means and routes, and multiplicity of areas served where 0=Very Poor, 2=Poor, 4=Fair, 6=Good, and 8=Optimal a. For local participants: 0 2 4 6 8 . For regional or remote participants: 0 2 4 6 8 2) Congestion of access, traffic, and parking: 0 2 4 6 8) Safety of access and neighborhood: 0 2 4 6 8 Add points assigned for 1a, 1b, 2 and 3: 22 Use chart below to assign level. 1=0-5 points, 2= 6-10 points, 3= 11-14 points, 4= 15-19 points, 5= 20-24 points		
2.1.3. Hours	Hours of operation are geared to the needs of participants.	1) Hours of operation are extremely limited and rigidly set; 2) Hours of operation are limited; 3) Program in operation 40 hours per week but might not be open during needed hours; 4) Program in operation more than 40 hours per week and is open some evenings and weekend hours; 5) Hours conform to the hours most needed by individuals.		
2.1.4. Cost	Programs are either free or charge a nominal fee. Program use is not dependent on ability to pay.	1) Services are priced without regard to ability to pay or are dependent on insurance or income; 2) Services are modestly priced but there are no provisions made for an individual's ability to pay; 3) Services are modestly priced and there are some provisions for an individual's ability to pay; 4) All services are free or modestly priced and there are provisions made for an individual's ability to pay; 5) All services are free of charge.		
2.1.5. Accessibility	Efforts are made to ensure that consumers with physical and sensory as well as psychiatric disabilities can participate in programming.	1) No attention to accommodation of persons with physical and sensory disabilities or major gaps: gross lack of accessibility is readily apparent to observers; 2) Some provisions made for persons with physical/sensory disabilities, but still lack of accessibility may create barriers for some potential participants; 3) Generally accessible but improvements can be imagined (i.e., program has accessible entrance and toilets but lacks TTD); 4) Fully accessible to persons with wide range of disabilities and committed to accommodating individual differences.		

Ingredient	Definition	Anchored Scale	Score	Notes
2.2.1. Lack of coerciveness	The program provides a non-coercive milieu in which fears due to past traumatization are appreciated and assuaged, including trauma induced by the mental health system. There is no threat of commitment, clinical diagnosis, or unwanted treatment except in cases of suicide or physical danger to other participants.	1) People are required to be in formal treatment to participate in the program; 2) The Program strongly encourages but does not require individuals to be in formal treatment to participate in Program activities; 3) The Program strongly encourages individuals to participate in peer support programs; 4) The Program encourages individuals to participate in peer support programs; 5) The Program encourages people to choose whether or not to participate in the program. Behaviors are tolerated as long as they are not harmful to others.		
2.2.2. Program Rules	Norms/rules to protect the physical safety of participants are developed by consumers for consumers – either by the participants themselves or by consumer staff – and they are agreed to by all participants.	1) Inadequate controls. Participants are frequently victimized; 2) Inadequate controls. Consumers sometimes feel unsafe or victims of crimes; 3) Adequate controls and safeguards so participants feel safe from physical harm. Rules not developed by participants. 4) Adequate controls and safeguards so participants feel safe from physical harm. Rules developed by participants. However there are not mechanisms in place when rules are violated; 5) Adequate controls and safeguards so participants feel safe from physical harm. Rules developed by participants and mechanisms are in place when rules are violated.		
2.3.1. Physical Environment	Working toward common goals in a comfortable setting creates a sense of belonging and support.	1) Lack of physical comfort would be perceived as intolerable, or as extremely objectionable by even a sizeable minority of participants or fellow citizens who might be placed into such circumstances; 2) Shortcomings in physical comfort are significant, but would rarely be considered intolerable; 3) Settings in which the vast majority of individuals would feel physically comfortable, even though there may be obvious room for improvement; 4) Project not only meets all obvious requirements for physical comfort, but also makes extensive efforts to ensure that even relatively minor aspects of the environment add to the participant's physical comfort.		

Ingredient	Definition	Anchored Scale	Score	Notes
2.3.2. Social Environment	Rigid distinctions between "provider" and "client" do not exist. While some program components may be structured, there remains a sense of freedom and self-expression.	1) An obvious devaluation of the participant is apparent in attempts to differentiate program participants from staff, e.g., via excessive separation of staff and participants, or separation of staff and participant areas; 2) Distinct minor deficiencies exist, e.g., Participants may knock on staff doors but not vice versa; 3) Staff attitudes are somewhat cold and distant even if correct; 4) Staff members treat participants with openness, directness and sincerity, although certain minor compromises are apparent; 5) Staff/ participant interaction in the project appears near ideal.		
2.3.3. Sense of Community	The Program provides a sense of fellowship, in which people care about each other and create community together.	1) Formal relationships but little opportunity for participants to informally relate with others or develop a sense of belonging; 2) Formal relationships but some opportunity for participants to informally relate with others or develop a sense of belonging; 3) Both formal and informal relationships with considerable opportunities for participants to informally relate with others or develop a sense of belonging; 4) General comfort among participants characterized by extensive opportunity for warm, interpersonal interactions, sense of belonging and numerous opportunities to socialize with other Program participants.		
3.1. Peer Principle	Relationships are based upon shared experiences and values. They are characterized by reciprocity and mutuality. A peer relationship implies equality, along with mutual acceptance and mutual respect.	1) Self-disclosure limited/no staff or leaders are identified as mental health consumers. Those staff and leaders who are mental health consumers do not reveal this to program participants; 2) Some self-disclosure by program staff and leaders, but this is limited to one or a few instances; 3) Self-disclosure is common, but not universal within program, among staff/leaders, and participants. There is still evidence of significant imbalance/distance between staff and leaders, and participants; 4) Self-disclosure is almost universal – both participants and staff/leaders characterize relationships as mutual/reciprocal.		

Ingredient	Definition	Anchored Scale	Score	Notes
3.3.1. Personal Empowerment	Empowerment is honored as a basis of recovery. It is defined as a sense of personal strength and efficacy, with self-direction and control over one's life.	1) No one agreed that being involved with Program has helped make positive changes in their lives; 2) Some agreed that being involved with Program has helped make positive changes in their lives; 3) About half agreed that being involved with Program has helped make positive changes in their lives; 4) Most agreed that being involved with Program has helped make positive changes in their lives; 5) Virtually everyone/all agreed that being involved with Program has helped make positive changes in their lives		
3.3.2. Personal Accountability	Consumers are expected, but not forced to be accountable for their actions and to act responsibly. Self-reliance is encouraged.	1) Program staff and leaders are often patronizing, placing few or no demands on program participants; 2) Program staff and leaders are somewhat patronizing, placing few or no demands on program participants; 3) Program staff and leaders are rarely patronizing, but place few demands on program participants; 4) Program staff and leaders are never patronizing, and place modest demands on program participants; 5) Program staff and leaders encourage a high level of accountability and self-reliance on program participants		
3.3.3. Group Empowerment	Belonging to an organized group that is recognized by the larger community contributes to the personal empowerment of the individuals within it. Both personal empowerment and group empowerment can be going on at the same time. As a group, the Program has the capacity to impact the systems that affect participants' lives. Consumers participate in systems level activities at their own pace.	1) No recognition of belonging to a group; 2) Some recognition and feeling of membership to a group; 3) Significant recognition and feeling of membership to the group. Awards opportunity for participants to contribute to program activity and planning; 4) High recognition and feeling of membership to the group. Awards great opportunity for participant to contribute to program activity and planning within, and beyond the group.		
3.4. Choice	Participation is completely voluntary, and all programs are elective and non-coercive. Choice of services includes the right to choose none. Consumers are regarded as experts in defining their own experiences and choosing Program or professional services that best suit them. Problems to be addressed are those identified by the consumer, not by professionals.	1) Limited choice is apparent to participant. Participation is involuntary; 2) Individuals can choose to participate or not; 3) Individuals have the choice to participate, and the opportunity to choose between at least two activities; 4) Individuals have the choice to participate, and the opportunity to choose between at least two activities with different levels/forms of participation; 5 Individuals have the choice to participate from a wide array of program activities with different levels/forms of participation, including the opportunity to shape the activity.		

Ingredient	Definition	Anchored Scale	Score	Notes
3.5. Recovery	We believe in recovery. The recovery process is different for each individual. It is never defined rigidly, or forced on others by a Program. Recovery describes a positive process that acknowledges strengths and enhances wellbeing. Programs regard recovery as a normal human process that is unique for each individual. And like all human processes, recovery takes time and involves a whole range of human experiences. It may include ups and downs and also periods of no apparent change.	1) Little or no recognition of a need for a hope-oriented approach in the mission statement or in materials describing the program; 2) There is some recognition of a need for a hope-oriented approach in the mission statement or in materials describing the program; 3) The mission statement and materials describing the program include a clear statement of a hope-oriented approach; 4) Not only does the mission statement and materials describing the program include a clear statement of a hope-oriented approach but also participants can articulate approach.		
3.6. Acceptance and Respect for Diversity	Empowerment and hope are nourished through acceptance of people, as they are "warts and all." All behaviors are understood in ordinary human terms, never according to clinical interpretations. Consumers respect each other for the person they are rather than for the person they should be. Every person is afforded acceptance, respect and understanding based on his/her uniqueness and value as a human individual.	1) Rigid expectations of behavior across a wide range of daily domains; 2) Rigid expectations of behavior across one important domain. Less regimented; 3) Subtle expectations communicated about personal behavior but these are limited and are not readily enforced; 4) Acceptance of some non-dangerous behaviors; 5) Acceptance of a wide range of non-dangerous behaviors without threatening either continued Program participation.		
3.7.1. Spiritual Growth	Spiritual beliefs and subjective experiences are respected, not labeled as symptoms of illness.	1) Spirituality/religious expression is not allowed or is discouraged within the program; 2) The expression of spiritual or religious insights is allowed within the program.		
4.1.2. Informal Peer Support	Informal unscheduled groups and informal individual relationships	1) Program provides no opportunities for participants to provide support to another on an informal basis; 2) Program provides few opportunities for participants to provide support to another on an informal basis; 3) Program provides some opportunities for participants to provide support to another on an informal basis; 4) Program provides the opportunity for and supports the development of strong mutual peer relationships.		

Ingredient	Definition	Anchored Scale	Score	Notes
4.2. Telling Our Stories	Personal accounts of life experiences are embedded in all forms of peer support and education. Open discussion occurs in peer support groups or among individuals. Sharing these life experiences may also be a tool for public education, thus becoming an effective means of eliminating stigma and making consumers more accepted within their community.	1) Sharing stories is actively discouraged on the basis that it might make the individual or others feel uncomfortable or upset; 2) Some provisions made for sharing of stories about one's personal life and beliefs. These opportunities are limited or superficial; 3) Program limits telling stories to social situations; 4) Program provides regular opportunities for sharing stories among program participants; 5) Program provides numerous formal and informal opportunities for sharing stories within the program and to the larger community.		
4.2.1. Artistic Expression		1) No provision or outlet for artistic expression; 2) Some provision or outlet for artistic expression, but minor or rare; 3) A regular outlet (such as an art class, or regular newsletter) but only one; 4) Regular outlets that provide opportunity for artistic expression; 5) Multiple regular outlets that provide opportunity for artistic expression, within a variety of media. These opportunities are individualized enabling all who are interested to participate.		
4.3. Consciousness Raising	Small support or conversation groups allow participants to "tell our stories" or share common experiences. These groups may be formal peer support groups or casual, ad hoc conversations. Participants receive information about the consumer movement. New participants discover commonality with others, and this often produces the first dramatic change in perspective from despair to hope and empowerment.	1) Most individuals think of themselves as uniquely ill or malfunctioning, keep their illness a secret and feel disconnected and ashamed of it; 2) Some individuals think of themselves as uniquely ill or malfunctioning, keep their illness a secret, and feel disconnected and ashamed of it; 3) Individuals do not think of themselves as ill or malfunctioning. They feel comfortable in connecting to a community but may not feel confident in contributing to this community; 4) Individuals recognize themselves as valuable members of a larger community with unique identities, and feel confident contributing to this community.		

Ingredient	Definition	Anchored Scale	Score	Notes
4.4.1. Informal Crisis Prevention	Involuntary commitment is minimized through individual or group peer support, or by peer counselors, or by education and advocacy, by addressing problems before they escalate.	1) No informal provisions made for crisis prevention; 2) At least one avenue provided for informal crisis prevention, which may be inconsistent; 3) At least one consistent avenue provided for informal crisis prevention, which appears to be effective in providing a regular, and sometimes physical outreach to participants; 4) Multiple avenues provided for informal crisis prevention and these appear to be effective in providing a regular, and sometimes physical outreach to participants.		
5.1.2. Receiving Informal Problem-Solving Support	Program programs or individuals teach and model practical skills and promote strategies related to personal issues, treatment, and support needs. The focus is on everyday, practical solutions to human concerns	1) Small proportion (0-19%) report that they have received informal support in self-management or problem solving assistance; 2) Significant minority (20-39%) report that they have received informal support in self-management or problem-solving assistance; 3) About half (40-59%) report that they have received informal support in self-management or problem solving assistance; 4) A majority (60-79%) report that they have received informal support in self-management or problem solving assistance; 5) Most (80-100%) report that they have received informal support in self-management or problem-solving assistance.		
6.1.1. Formal Self-Advocacy Activities	Program participants learn to identify their own needs and to advocate for themselves when there are gaps in services. Program participants learn to become active partners in developing their own service plans with traditional services. Consumers learn to deal effectively with entitlement agencies and other services.	1) No formal curriculum on self-advocacy; no evidence of informal self-advocacy activities; 2) Small proportion (1-24%) of program participants has participated in formal training activities related to self-advocacy or informal opportunities leading to peer-to-peer learning about self-advocacy; 3) Substantial minority (25-49%) of participants have participated in formal training activities related to self-advocacy or informal opportunities leading to peer-to-peer learning about self-advocacy; 4) A majority (50-74%) of participants has participated in formal training activities related to self-advocacy or informal opportunities leading to peer-to-peer learning about self-advocacy; 5) Most or all (75-100%) of participants have participated in formal training activities related to self-advocacy or informal opportunities leading to peer-to-peer learning about self-advocacy.		

Ingredient	Definition	Anchored Scale	Score	Notes
6.2. Peer Advocacy	Program participants assist other consumers in resolving problems they may encounter on a daily basis in the community such as problems with treatment providers, community service agencies, family members, neighbors, landlords, other peers, etc.	1) No evidence of peer advocacy; 2) Some evidence of peer advocacy, rare occurrences or on a one-time basis; 3) Some evidence of peer advocacy that happens in relation to other activities; 4) Evidence of formal peer advocacy, primarily staff of programs; 5) Most participants are involved in providing peer advocacy. (Requirement) All members consider themselves as peer advocates.		
6.2.1. Outreach to Participants		1) No evidence of outreach to participants; 2) Some, but rare evidence that the Program informs participants [through multiple channels] by using internet, newsletters, regional conferences, faxes, etc.; 3) Some evidence that the Program regularly informs participants [through multiple channels] by using internet, newsletters, regional conferences, faxes, etc.; 4) Most participants are informed about the program [through multiple channels] through the internet, newsletters, regional conferences, faxes, etc.; Regular and strong advocacy content; 5) All of the participants are informed about the Program through multiple channels, i.e. the internet, regular newsletters, regional conferences, faxes, etc. Regular and strong advocacy content.		

Intentional Peer Support Core Competencies – FULL VERSION

Human Services Research Institute, Revised December 29, 2011

Staff ID # (if applicable): _____   **Date:** _____

Method:
☐ 1. Guest scoring team member (ID #: ___)   ☐ 4. Team member scoring group
☐ 2. Team member scoring other team member (ID #: ___)   ☐ 5. Evaluator scoring group
☐ 3. Team member scoring self   ☐ 6. Guest scoring group
☐ Other: _____

Criterion 1: Demonstrates the intention of learning as opposed to the intention of helping					
Description	• Be curious rather than operating from one's own agenda • Be open to new ways of looking at things rather than imposing or guiding the other to look at things in a certain way • Stand on a position of not knowing • Ask questions to explore meaning and further understanding		• Be aware of one's judgments and preferences • Challenge any assumption that the other is fragile and therefore does not have to take responsibility in relationships • Be willing to change • Have the courage to try and see what emerges rather than controlling the outcome (i.e. try to get the person to get or do things one wants) • Shift focus away from problems and problem-solving		
Score	1	2	3	4	5
Rating Scale	Usually assumes the role of helper, with little effort to learn about the other.	Makes some effort to learn about the other, but usually begins with or lapses into helper role.	Combines helper and learner role in approximately equal measure.	Primarily learning about the other or from the other.	Shows intention of mutual learning.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	You look depressed. You should write in your journal.	How's it going? You look a little down. Maybe you should write in your journal.	How's it going? You look a little down, but I'd like to know your perspective.	I realize that I don't know you beyond talking about your experience. I'd like to get to know you better.	I realize that I don't know you very well other than the conversations we've had about your experience. I'd love for us to get to know each other more.
Outcome	Naming or simplifying the other's experience and taking control of the solution.				Learning for both people (e.g. both say things like, "I've never thought about it that way before").

Criterion 2: Focuses on the relationship (rather than individual) and how it is working for both people					
Description	• Pay attention to the dynamics in the relationship (e.g., connection/disconnection) • Reflect the way in which people relate to one another • Be aware of and talk about power imbalances and power dynamics			• Be aware that meaning gets made in relationships • Share (in a way that can be heard) what one is feeling and thinking, and then negotiate if needed	
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Allows for little or no discussion of the relationship. Focuses on an outcome for the other.	Gives some attention to the relationship, but mostly focuses on an outcome for the other.	Communicates feelings in the relationship, but does not sufficiently address the topic of the relationship.	Communicates feelings in the relationship, but not sufficiently to explore how it looks like for the other.	Addresses the topic of the relationship sufficiently to ensure that it is working for both people.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	I'm here to support you in your recovery.	Let's share some ideas about what might support your recovery.	I got frustrated in our conversation last week, but how are you doing today?	I got frustrated in our conversation last week. I wish you'd be more open with me in the future.	I got frustrated in our conversation last week. I wonder how it was for you.
Outcome	Expert/client relationship.	Friendly, helping relationship with a focus on the other.	A disconnect is noticed, but focus is still on the other. No movement toward reconnection.	Movement toward reconnection.	Both people have a willingness to ask for what they need and a responsibility to consider the views of others. A focus on taking care of the relationship rather than taking care of each other. An understanding that both people are responsible for themselves and their part of any relationship.

Criterion 3: Has awareness of own intentions (e.g., agendas, assumptions)					
Description	Be self-reflective Own one's motivation Don't act on one's own agenda Be open about assumptions (and open to being challenged)				
Score	1	2	3	4	5
Rating Scale	Demonstrates limited awareness of how one's values and assumptions are affecting the interaction.	Has some recognition of one's values and assumptions but often imposes these on the interaction.	Generally able to separate one's values and assumptions but has limited awareness about the ways they can be imposed on the interaction.	Generally aware of one's values and assumptions and acknowledges it if they are imposed on the interaction.	Demonstrates full awareness of one's values and assumptions and seldom if ever imposes these on the interaction.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	Why don't you listen to me when I tell you what worked for me?	I realize that not everything that worked for me will work for you, but at least you should try it.	I realize that not everything that worked for me will work for you.	I realize I've quietly been pushing my own agenda. I'd like to try work towards noticing when my agenda seems to come up.	How would you like me to respond when you tell me you're depressed?
Outcome	Use of power to push one's own agenda.				Shared power and openness to creating possibilities.

Criterion 4: Values and validates others and demonstrates mutual empathy					
Description	• Be respectful of the story being told • Maintain non-judgment • Listen deeply for themes • Refrain from refutation		• Be honest • Be authentic • Show the other what one understands and how one is affected by the story		
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Almost never demonstrates that the other is valued or validates the other in the interaction. Imposes one's judgment on the other.	Demonstrates that the other is valued or validates the other, but imposes one's judgment on the other.	Demonstrates that the other is valued or validates the other, but responds to the other based on one's own values.	Demonstrates that the other is valued or validates the other. Refrains from responding based on one's own values, and tries to get the other's perspective.	Demonstrates that the other is valued or validates the other, and shares what resonates and/ or relevant personal experience.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	Why don't you just get over it? You can't always be depressed.	Depression is hard, but maybe you're too focused on it.	It must be hard for you. You must be tired, but you have to remember that you'll get through it.	Sounds like things have been really hard for you lately.	I can imagine that it's been really hard for you lately. I remember a time when it seemed the only thing I felt was depressed.
Outcome	Invalidation and disconnection from the other.				People feel seen, heard and validated and know that they're not alone.

Criterion 5: Uses language that describes things as they are experienced; uses language that is free of medical jargon, assumptions, judgments, generalizations and characterizations					
Description	• Refrain from using language of medical jargon (e.g., decompensate, psychotic) • Refrain from using language of assumptions (e.g., she must be sick, have you taken your medication?) • Refrain from using language of judgments (e.g., I am stupid. I should have known better)		• Refrain from using language of generalizations (e.g., women are sensitive) • Refrain from using language of characterizations (e.g., she is an advocate)		
Score	1	2	3	4	5
Rating Scale	Nearly always uses jargon and language that implies helping relationship in the treatment context.	Uses person-first language within a medical framework and language that implies a helping relationship in the treatment context.	Uses language that describes things as they are experienced and language that implies a helping relationship in the treatment context.	Seldom uses jargon and uses language that implies a helping relationship in the peer support context.	Almost never uses jargon, and uses language that describes things as they are experienced, free of assumptions about the relationship.
Example: *Jim works in a peer run crisis center. He is describing who he works with.*	We work only with SMI who are decompensating.	We work with people with mental illness who are in crisis.	We work with people in crisis to help them manage their symptoms.	We support people in distress by offering our own recovery experiences.	We welcome people who want to move through distressing experiences differently than they have in the past.
Outcome	People are judged, categorized and assessed, reinforcing an illness framework.				People no longer see themselves through the lens of a diagnosis and the assumptions of others.

Criterion 6: Understands how a person's past experiences impacts who they are, how they think, and how they relate					
Description	• Collaboratively inquire into how people have learned the ways in which they see themselves and others and relate with others • Show respect of the other		• Work to become less reactive and judgmental • Have space for reflecting different views and exploring new ways of thinking and relating		
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Assesses the other's experience based on the medical framework.	Assesses the other's experience based not necessarily on the medical framework but nonetheless on one's own judgment.	Assesses the other's experience without any particular pre-judgments or assumptions.	Tries to understand the other's experience in the context of his or her past experiences.	Tries to build mutual understanding of the other's experience. Negotiates meaning and reflects on how both people make meaning.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	It sounds like your medication is off. Have you talked to your doctor?	You know trauma leads to depression!	There are many factors that contribute to depression.	What happened to you that lead to you feeling depressed so much of time?	I wonder what depressed means for you. I know there was a time when I learned to think of my feelings as dangerous and so it was easy to adopt medical language.
Outcome	Reinforcement of an illness identity and narrowed framework for understanding feelings. Peer supporter becomes assessor and holder of truth.				Acceptance, interest, and curiosity about different ways of thinking. Valuing other perspectives/truths as opportunities for personal growth and discovery. People begin to understand their experiences based on what's happened to them rather than what's wrong with them. The effects of trauma are not viewed as illness but rather a reaction to what has been experienced.

Criterion 7: Invites conversation that shifts from a problem focus to a creating focus					
Description	• Open up new perspectives, but do not impose one's own perspective • Reflect team type dialogue		• Does not necessarily mean avoiding topics that are perceived as problems		
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Focuses on problems, problem solving, and giving advice.	Focuses on problems and explores solutions with the other.	Does not focus on problems and refrains from problem solving.	Focuses on what the other wants.	Focuses on the relationship and explores new ways of relating.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	You should try…	What has worked for you in the past?	I wonder what we would talk about if the focus wasn't on depression.	I wonder how you'd rather feel.	I realize that I've been simply trying to solve this for you. I wonder what we might do differently.
Outcome	Peer supporter judges success by the extent to which he or she helps others with their problems.				Person feels validated yet curious about other ways of thinking.

Criterion 8: Gives and receives difficult messages with awareness of other worldviews as well as one's own					
Description	• Be aware of own reactions • Be aware of own judgments and preferences		• Ask what the other sees • Communicate in a way that the other can hear with observational, non-judgmental language		
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Shows little awareness of one's feelings and blames the other.	Demonstrates awareness of one's feelings, but blames the other for them.	Demonstrates awareness of one's feelings and refrains from blaming the other.	Demonstrates awareness of one's feelings and describes them with observational language.	Demonstrates awareness of one's feelings and describes them in a way the other can hear; is curious about what it is like for the other.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	No one is depressed all the time.	I'm finding that I've been really frustrated with our conversations. No one is depressed all the time.	I'm finding that I've been really frustrated with our conversations.	I'm finding that I've been really frustrated with our conversations that have been so focused on depression.	What has it been like for you that our conversations have been so focused on depression? I know that sometimes I find it difficult.
Outcome	Total disconnect and lack of honesty (talking about people behind their backs).				Trust and depth in the relationship, leading to a willingness to tolerate discomfort in the relationship

Criterion 9: Has ability to sit with discomfort and negotiate fear, anger, and conflict					
Description	• Be aware of one's reactions (sensing, feeling, thinking, action) and notice discomfort • Be tolerant with dissonance/disturbance • Resist an urge to control • Make space for the other to tell his/her story • Sit with the other's pain • Know one's limits		• Be honest and authentic • Remember one's own feelings are important too • Try to understand where the other stands • Speak in a way that the other can hear • Inquire what both need and want • Self-reflect and acknowledge fear, anger, and conflict • Ask if this is an old response to some tough feelings and if there is a way to talk together both feel comfortable enough		
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Not able to sit with discomfort. Imposes a solution based on one's assessment.	Not able to sit with discomfort. Suggests a solution based on one's assessment.	Able to sit with discomfort. Makes space for the other to consider a solution based on one's assessment.	Able to sit with discomfort. Makes space to explore solutions together.	Able to sit with discomfort. Makes space to explore meaning and negotiate fear, anger, and conflict.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed. Today she tells Sarah she's ready to end it!*	I'll have to call emergency services.	How serious are you? Do you think we should call emergency services?	I feel afraid when you say you're going to end it. I wonder if we should call emergency services.	I feel afraid when you say you're going to end it. I wonder what we can do to make you feel better.	I feel afraid when you say you're going to end it, but I realize I don't know what you mean by saying you're ready to end it.
Outcome	The "safety" problem is passed on to a professional who "knows more" than the other. Results in coercion.				People consider discomfort a natural part of the learning process. Increased ability to work through hard times without professional intervention. People feel more capable and have hope even in difficult situations.

Criterion 10: Attends and fully participates in co-supervision and has the desire and ability to self-reflect					
Description	• Describe interactions with observational, non-judgmental language – have a distance • Be aware of one's feeling and thinking, and be honest about them • Pay attention to what strikes and intrigues		• Suspend one's own judgments and remain open to other perspectives • Be comfortable with not knowing • Maintain an intention of learning		
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Never reflects on one's way of relating. Gets defensive and blames the other.	Has limited self-reflection and little awareness of one's assumptions about the other.	Somewhat self-reflective and refrains from making assumptions about the other.	Self-reflective on relationship patterns and one's intention. Limited awareness of one's values.	Self-reflective on relationship patterns and one's own intentions. Open to new ways of relating.
Example: *Bruce has been working with Joe whom he's been getting frustrated by. Every time Joe says he's going to do something, he doesn't do it.*	Joe is a difficult client. He's just not motivated.	I feel frustrated because of Joes' lack of motivation.	I don't know what Joe wants to do with his life.	I realize I've been trying to get Joe to do something based on my agenda, but he's got so much potential.	I realize I've been trying to get Joe to do something based on my agenda. I wonder if I should go apologize to him.
Outcome	People blame others.				People are self-reflective and able to consider other ways of relating.

Intentional Peer Support Core Competencies – SCORESHEET

Human Services Research Institute, Revised March 2013

Staff ID (if applicable): _____   **Date:** _____

Method:
❐ 1. Guest scoring team member (#: ___)   ❐ 4. Team member scoring group
❐ 2. Team member scoring other team member (#: ___)   ❐ 5. Evaluator scoring group
❐ 3. Team member scoring self   ❐ 6. Guest scoring group
❐ Other: _____

Criterion	Rating (1 to 5)
1. Demonstrates the intention of learning as opposed to the intention of helping	
2. Focuses on the relationship (rather than individual) and how it is working for both people	
3. Has awareness of own intentions (e.g., agendas, assumptions)	
4. Values and validates others and demonstrates mutual empathy	
5. Uses language that describes things as they are experienced; uses language that is free of medical jargon, assumptions, judgments, generalizations and characterizations	
6. Understands how a person's past experiences impacts who they are, how they think, and how they relate	
7. Invites conversation that shifts from a problem focus to a creating focus	
8. Gives and receives difficult messages with awareness of other worldviews as well as one's own	
9. Has ability to sit with discomfort and negotiate fear/anger/conflict	
10. Attends and fully participates in co-supervision and has the desire and ability to self-reflect	
Total Score	

Rose House Logic Model

| Outcome Statement

Should be the same statements as

"Outcome" on Logic Model | Expected target # _or_ % of underlined customers expected to achieve outcome | List instruments/tools used to collect data and who completes it | Actual, outcomes achieved

Q1/(YTD) | Actual, outcomes achieved

Q2/(YTD) | Actual, outcomes achieved

Q3/(YTD) | Actual, outcomes achieved

Q4/(YTD) |
|---|---|---|---|---|---|---|
| **Rose House Services**: PEOPLe, Inc. will provide persons served – including Rose House guests (current and former), persons in crisis in the community, and Warm Line callers – with Hospital Diversion services, including Peer Support and Counseling, Social Inclusion (including Recreational Activities), Wellness & Recovery Tools, and Transportation Services **(_for individual service units see categories below_)** | # of **unduplicated** individuals will have received Rose House services. | Data is collected using excel spreadsheet outlook calendar and case notes | 0 (0 YTD) | 0 (0 YTD) | 0 (0 YTD) | 0 (0 YTD) |
| | # of **duplicated** individuals will have received Rose House services. | Data is collected using excel spreadsheet outlook calendar and case notes | 0 (0 YTD) | 0 (0 YTD) | 0 (0 YTD) | 0 (0 YTD) |
| **Rose House Guest Stays:** Individuals will stay in a peer-operated hospital diversion houses designed to alleviate one's emotional distress in a home-like safe and secure environment, instead of a hospital or emergency setting. | # of **unduplicated** individuals will have stayed at the Rose House (measured as new admissions during FY14). | Data is collected using excel spreadsheet outlook calendar and case notes | 0 (0 YTD) | 0 (0 YTD) | 0 (0 YTD) | 0 (0 YTD) |
| | # of **duplicated** individuals will have stayed at the Rose House (measured as sum of total residence days during FY14). | Data is collected using excel spreadsheet outlook calendar and case notes | 0 (0 YTD) | 0 (0 YTD) | 0 (0 YTD) | 0 (0 YTD) |

Peer Support & Counseling: Using the mutuality of lived experiences to engage with individuals – demonstrating empathy, trust, respect, and collaboration – to promote possibilities for change, and to help individuals move beyond previously-held self-concepts based on deficiencies, weaknesses, disabilities, psychiatric diagnoses, and trauma. **COLLAPSE**	# of **duplicated** individuals will have received One-to-One Peer Counseling	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)
	# of **duplicated** individuals will have attended Peer-led Support Groups	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)
	# of **Peer-led Support Groups** will be held at the Rose House.	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)
Direct Linkages: Staff will directly connect ("warm hand-offs") persons served to **other PEOPLe, Inc. programs and services.**	# of **Direct Linkages** ("warm hand-off") to other PEOPLe, Inc. programs and services.	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)
Direct Linkages: Staff will directly connect ("warm hand-offs") persons served to **outside agencies / community-based services**, including clinical services, care coordination/case management, educational remediation, public assistance, social security and disability benefits, health homes, disability resources, probation and post-sentencing assistance, transportation and livery services, substance abuse meetings and support groups, chemical dependency rehabilitation, et.al.	# of **Direct Linkages** ("warm hand-off") to outside agencies / community-based services.	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)
Social Inclusion: Facilitating socialization opportunities (including Recreational Activities) that promote the learning of life	2,500 **duplicated** individuals will participate in activities that promote social inclusion.	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)

skills, foster community, and create new support systems.						
Wellness and Recovery Tools: Helping individuals to learn about, develop, and refine personalized tools for managing their mental wellness, including Evidence-based Practices (such as WRAP, Advance Directives).	150 **duplicated** individuals will have worked on Wellness & Recovery Tools.	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)
Transportation Services: Staff will provide individuals with transport to and from their homes/ communities, PEOPLe, Inc. project sites, and outside agencies / community-based services that help participants transition to recovery and mental wellness.	2,500 **duplicated** individuals will have received Transportation Services.	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)
Off-site Visits: Individuals in need of Rose House Services, who do not require a full residence stay, will receive in-person visits.	# of **Off-site Visits** conducted by Rose House staff.	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)
Warm Line Calls: Individuals in need of Rose House services will have access to peer-run support telephone lines	# of **Warm Line Calls received** by Rose House staff.	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)
Putnam Crisis Line Calls: Individuals in Putnam County will have access to a free, confidential, telephone service to assist them when they are experiencing a mental health crisis.	# of **Putnam Crisis Line Calls** received by Rose House staff.	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)
Putnam Crisis Line Calls Dispatching 9-1-1 Services:	# of Putnam Crisis Line Calls **dispatching 9-1-1 services**.	Data is collected using excel spreadsheet outlook calendar and case notes	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)	0 (0 YTD)

Program Surveys and Satisfaction

Rose House Survey

Part 1

Directions: Please ☑ the appropriate response for the following questions:

1. Gender   2. Age_____   3.Where were you last hospitalized?

☐ Male

_____

☐ Female

4. What is your ethnicity? Check all that apply:

- ☐ White
- ☐ Black, African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Asian, please specify _____
- ☐ Other Pacific Islander, please specify _____

Some other race, please specify _____

Yes, other Spanish/Hispanic/Latino, please specify _____

5. Are you Spanish/Hispanic/Latino? Mark the "no" box if NOT Spanish/Hispanic/Latino

☐ No, not Spanish/Hispanic/Latino   ☐ Yes, Puerto Rican

☐ Yes, Mexican, Mexican Am.,
   Chicano   ☐ Yes, Cuban

Yes, other Spanish/Hispanic/Latino, please specify_____

6. Your highest educational level (please fill in one choice).

    ☐   Less than high school diploma
    ☐   GED/high school diploma
    ☐   Associate's Degree
    ☐   Bachelor's Degree
    ☐   Graduate Degree (ex. MA, PhD)

7. Individual economic status (please fill in one choice)

    ☐ $15,000 or less per year

    ☐ $15,001 - $30,000 per year

    ☐ $30,001 - $45,000 per year

    ☐ $45,001 - $60,000 per year

    ☐ $60,001 - $75,000 per year

    ☐ $75,001 or more per year

Go to Part 2

Part 2

Directions: Please ☑ if you have been involved in any of the following activities in the **last week**

	YES	NO
8. Gone for a walk	☐	☐
9. Gone to a movie or play (or any entertainment outside the house)	☐	☐
10. Gone to a restaurant or coffee shop	☐	☐
11. Read a book, magazine, or newspaper	☐	☐
12. Gone to work/volunteer/vocation/school	☐	☐
13. Worked on a hobby/play a sport	☐	☐
14. Gone to a meeting of some organization or group. Including program-related meetings	☐	☐

Directions: Please ☑ your overall satisfaction with the previous activities you have marked above

	Satisfied	Dissatisfied	Not Sure
15. Walking	☐	☐	☐
16. The movies or a play (entertainment outside the house)	☐	☐	☐
17. Gone to a restaurant or coffee shop	☐	☐	☐
18. Read a book, magazine, or newspaper	☐	☐	☐
19. Working, volunteering, vocation or school	☐	☐	☐
20. Working on a hobby/play a sport	☐	☐	☐
21. At a meeting of some organization or group. Including program related meetings	☐	☐	☐

Directions: Using the scale below please ☑ how often you do the following:

	About Daily	About Weekly	About Monthly	Less than monthly	Not at all
22. Do things with a close friend	☐	☐	☐	☐	☐
23. Visit someone who does not live with you	☐	☐	☐	☐	☐
24. Telephone/e-mail someone who does not live with you	☐	☐	☐	☐	☐
25. Do something with another person that you planned ahead of time	☐	☐	☐	☐	☐
26. Spend time with someone whom you are intimately involved with and consider more than a friend (spouse, boyfriend, girlfriend or significant other)	☐	☐	☐	☐	☐

STOP

If you have had an inpatient hospitalization please complete **Part 3**

IF NOT…

Go directly to **Part 4**
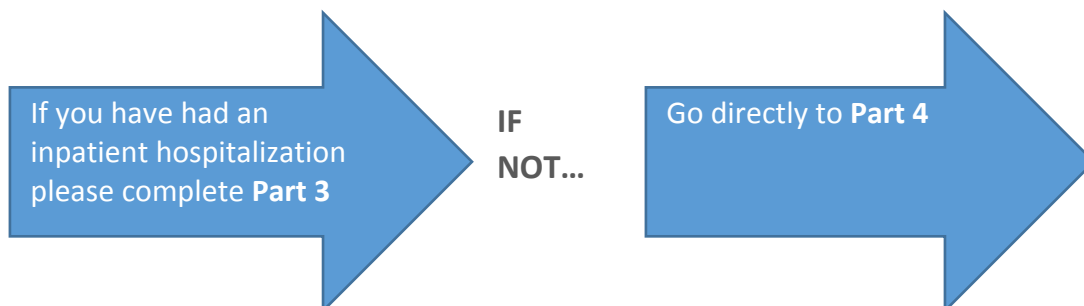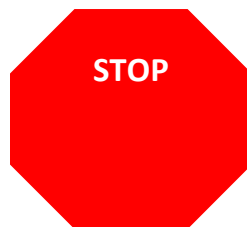
Part 3

Directions: Please ☑ the items that best describe your experience with Rose House, Hospital, Both, or Neither

	Rose House	Hospital	Both	Neither
27. Staff greeted you warmly upon intake	☐	☐	☐	☐
28. Staff orientated you to the program	☐	☐	☐	☐
29. Staff were non-judgmental	☐	☐	☐	☐
30. The program used recovery-based language	☐	☐	☐	☐
31. The program was trauma sensitive/trauma informed	☐	☐	☐	☐
32. Staff discussed expectations of you and the program	☐	☐	☐	☐
33. Staff encouraged your involvement in treatment planning	☐	☐	☐	☐
34. Staff discussed risks and benefits of treatment	☐	☐	☐	☐

Directions: Please ☑ items that best describe the Staff at Rose House, Hospital or Both

	Rose House	Hospital	Both	Neither
35. Staff were available 24/7	☐	☐	☐	☐
36. Staff were respectful of clients	☐	☐	☐	☐
37. Staff encouraged recovery	☐	☐	☐	☐
38. Staff spent time with you	☐	☐	☐	☐
39. Staff provided active listening	☐	☐	☐	☐
40. Staff encouraged interaction with peers	☐	☐	☐	☐

Directions: Please ☑ the items that best describe the environment at Rose House, Hospital, Both, or Neither

	Rose House	Hospital	Both	Neither
41. Setting was comfortable	☐	☐	☐	☐
42. Clients had private space	☐	☐	☐	☐
43. Meals were available on client's schedule	☐	☐	☐	☐
44. Clients can set their own schedules	☐	☐	☐	☐

Go to Part 4 ▷

Part 4

Directions: Using the scale please ☑ these items regarding the Rose House program

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
45. Guests are greeted warmly when they arrive	☐	☐	☐	☐	☐
46. Guests get an orientation to the program and have a chance to discuss their reason for coming to Rose House	☐	☐	☐	☐	☐
47. Rose House uses language that is non-judgmental	☐	☐	☐	☐	☐
48. Rose House is trauma sensitive/trauma informed	☐	☐	☐	☐	☐
49. Expectations are discussed and agreed upon between guests and staff	☐	☐	☐	☐	☐
50. Decisions about guest services are made in a shared fashion between guests and staff	☐	☐	☐	☐	☐
51. "Risk" and potential benefits of recovery and growth are discussed with guests	☐	☐	☐	☐	☐
52. Peer run model at Rose House reduces the stigma of mental health	☐	☐	☐	☐	☐

Directions: Please ☑ these items regarding the Rose House staff

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
53. Staff are available 24/7	☐	☐	☐	☐	☐
54. Staff and guests are respected equally	☐	☐	☐	☐	☐
55. Guests are encouraged to try recovery	☐	☐	☐	☐	☐
56. The quality of time spent with staff was good	☐	☐	☐	☐	☐
57. Staff provided active listening	☐	☐	☐	☐	☐
58. Staff are non-judgmental	☐	☐	☐	☐	☐

Directions: Please ☑ these items regarding the peers at Rose House

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
59. Peers can provide companionship	⬚	⬚	⬚	⬚	⬚
60. Peers can provide feedback on my mental health	⬚	⬚	⬚	⬚	⬚
61. Peers can model recovery	⬚	⬚	⬚	⬚	⬚

Directions: Please ☑ about the Rose House environment

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
62. Rose House is a calm setting	⬚	⬚	⬚	⬚	⬚
63. Guests can cook their own food/eat when they want	⬚	⬚	⬚	⬚	⬚
64. Guests can come and go/set own schedules	⬚	⬚	⬚	⬚	⬚
65. The Rose House is a substance-free environment where sobriety is the norm	⬚	⬚	⬚	⬚	⬚

Go to Part 5

Part 5

Please indicate your responses to the following questions. You may write any comments you may have or answer these questions verbally.

66. Please tell us about your experiences in treatment as a consumer of mental health services? What was helped your recovery? What did not?

_____

_____

_____

_____

67. What else can you tell us about your experiences at Rose House?

_____

_____

_____

_____

68. What are the benefits of peer-provided care?

_____

_____

_____

_____

69. What are the weaknesses of peer-provided care?

_____

_____

_____

_____

70. What other comments would you like to make?

_____

_____

_____

_____

_____

Go to Part 6

Part 6

70. Will you allow us to contact you to follow up on the Rose House Survey?

Please ☑ Yes, or No

☐ Yes

☐ No

If Yes, please supply your contact information in the space provided. Your information will only be made available only to the researchers and will be kept confidential.

Name:_____

Address:_____

Phone #:_____

E-mail (optional):_____

—Thank You—

2nd Story Anonymous Guest Feedback Survey

Month/Year:_____   *Please fill out and place in locked box in the office;*
forms will be retrieved every two months

Please note that this feedback survey is for the purposes of the house and not connected to the research study.

If you had a choice between staying at 2ⁿᵈ Story or another healthcare facility, which would you choose and why?

What have you learned about yourself because of your stay here at 2ⁿᵈ Story?

What advice would you give to someone experiencing a mental health crisis for the first time?

How were you able to contribute to relationships and the 2ⁿᵈ Story environment/community while here?

Can you speak a little about something good that happened while you stayed here? Are you willing to speak about something that may have been bad?

Before filling out the next page, would you please share a thought or two on how we can improve?

How effective were the activities in assisting you in your personal recovery?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Excellent

The peer staff was helpful and supportive?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Excellent

I liked that we were able to have visitors.   Yes ☐   No ☐

IPS is an effective form of communication and staff practiced it well.

Yes ☐   No ☐   What's IPS? ☐

There were enough groups and outings.   Yes ☐   No ☐

What groups would you like to see?

I was able to discover a new path leading to health and well-being.   Yes ☐   No ☐

Feel the freedom to talk about your journey?

Draw a picture here?

Georgia Peer Support and Wellness Center Feedback Form

Revised July 1, 2012

Please give us your opinions and impressions of your time spent at the Peer Support and Wellness Center. *All answers are anonymous.*

Date_____ First time completing this form? Yes___   No____

Birthdate ___/ ____/_____   County of Residence_____

What services did you use? *Respite __ Wellness Activities __ Warm Line ___Computers___*

How many days did you spend in <u>respite</u> at the Peer Support and Wellness Center?__

Before coming to the Peer Support and Wellness Center, how many times had you been in a psychiatric hospital?_____

<u>Since</u> coming to the Peer Support and Wellness Center, how many times have you been in a psychiatric hospital? _____

Has the Peer Support and Wellness Center prevented a psychiatric hospitalization for you?

Yes___   No___ Possibly__

Will you tell us more about this?

_____

How would you compare respite to hospitalization?

_____

What would you have done if you had not contacted us for respite?

_____

Please check all that apply. I am:

currently employed____   want to be employed ____   seeking employment____

in supported employment____   actively interviewing for employment____

Which part of the Wellness Center did you like the best?

_____

Which part of the Wellness Center did you like the least?

_____

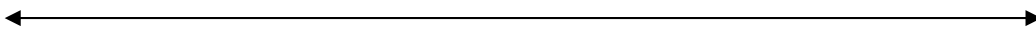**1. How effective were the activities toward reaching your personal recovery goals?**

○	○	○	○
Excellent	Good	Fair	Poor

2. How well did peer staff interact with you?

○	○	○	○
Excellent	Good	Fair	Poor

What can we do to improve the Peer Support and Wellness Center?

_____

_____

Do you have any additional comments, impressions, or opinions?

_____

_____

(Optional)

I am (check one):	What is the highest level of education you have achieved (check one)?:
___African American	
___Asian	___High School Grad/GED
___Caucasian	___Some College
___American Indian/Alaskan Native	___College Graduate
___Multiracial	___Post Graduate Degree
___Other (please specify)	(Masters, MD, PhD)
_____	
	Gender
Ethnicity:	___Male ___Female
___Hispanic ___Non Hispanic	

The Peer Support and Wellness Center is a project of the Georgia Mental Health Consumer Network in partnership with and funded through the Georgia Department of Behavioral Health and Developmental Disabilities

Afiya Peer Respite Impact Survey

Periodically, we want to check in and see if Afiya is having positive impact for the people who are staying there. Filling out this survey is entirely voluntary, but your time and willingness is much appreciated. Your feedback will not only help us make improvements at Afiya, but may also help to keep our funding and support the development of new peer respites. You can also complete this survey anonymously on-line by going to: www.surveymonkey.com/s/KFRMFFF. (For stays that occurred **BEFORE** July 1st, 2013, please use this link: www.surveymonkey.com/s/SVNVCFT)

Please complete this survey with your last stay at Afiya in mind. If you have stayed at Afiya multiple times since you last completed a survey, feel free to note that in the comments!

Please note: It is very important that we NOT receive duplicate surveys from people. (Surveys may be completed on paper, on-line or in person or by phone if requested.) **Please write, "This is not a duplicate survey" on the line below to confirm you have read and understand this!**

_____

1. When did your most recent stay take place? (Circle one):

Before July 1, 2013   Between July 1, 2013 – Dec 31, 2013   Between Jan 1, 2014 – June 30, 2014

2. About how long has it been since your stay took place? (This will help us to interpret some of the longer-term impact questions):

   Less than one month   1-2 months   3-6 months   7-9 months   10-12 months

3. Which of the following traditional services have you used in the past two years? (Circle all that apply)

   Psychiatric Hospital   Crisis Respite   Other Traditional Mental Health Services   None
   (Therapy, group home, clubhouse, etc.)

4. If Afiya had not been available, what would you have done instead? (Circle one)

   Go to hospital   Go to traditional respite   Go to family/friend's house   Stay home

   Other: _____

5. Help us understand your experience when staying in traditional settings verses Afiya. Read each statement and circle **all** settings for which the statement is true.

- I felt welcomed when I entered this setting

    Hospital   **Crisis Respite**   **Afiya**   **None**

- I was given clear explanations and information about the space and supports available

    Hospital   **Crisis Respite**   **Afiya**   **None**

- People working there consistently used respectful, recovery-oriented language

    Hospital   **Crisis Respite**   **Afiya**   **None**

- People working there treated me non-judgmentally

    Hospital   **Crisis Respite**   **Afiya**   **None**

- People working there were genuinely interested in learning more about me and my perspectives, fears, challenges, hopes, wants and dreams

    Hospital   **Crisis Respite**   **Afiya**   **None**

- There was opportunity for me to connect with and engage in mutual support with others who were staying in the space, **not** just those working there.

    Hospital   **Crisis Respite**   **Afiya**   **None**

- My stay there had long lasting, positive impact on my life

    Hospital   **Crisis Respite**   **Afiya**   **None**

6. Please rate each of the following on a scale of 1 to 5 based on how true the statement is (1 = not at all true and 5 = completely true. Mark N/A if you've never used that service.):

    A. Overall, I was treated with great dignity and respect while in this space.
        (1=Not at all; 5=Completely True)

        _____ Hospital   _____ Traditional Respite   _____ Afiya Peer Respite

    B. Overall, I had a lot of freedom to make choices and really be myself.
        (1=Not at all; 5=Completely True)

        _____ Hospital   _____ Traditional Respite   _____ Afiya Peer Respite

    C. Overall, my stay here was helpful, and I left feeling better than I arrived.
        (1=Not at all; 5=Completely True)

        _____ Hospital   _____ Traditional Respite   _____ Afiya Peer Respite

7. Since your stay at Afiya, has your life improved in any of the following areas? (Check all that apply)

    □ Housing   □ Mental/emotional/spiritual health

    □ Eating habits   □ Recovery from substance use

    □ Physical health   □ Relationships

    □ Sleeping habits   □ Setting personal goals

    □ Coping skills/tools   □ Self-advocacy

    □ Less contact with police   □ Fewer hospital or crisis visits

    □ Employment   □ Greater connection to community supports

8. Did this area improve, in part, because of your connection to Afiya?

        _____Yes   _____No   _____Not Sure

9. If yes, describe how Afiya impacted you in that area (attach additional paper as needed)

_____

_____

_____

_____

10. Overall, what was most helpful during your stay at Afiya? (Check all that apply)

□ Just being around others   □ My connection with someone else **staying** at Afiya

□ Had privacy   □ My connection with someone **working** at Afiya

□ Felt understood   □ Learned new tools / coping strategies

□ Felt heard   □ Able to accomplish specific goals

□ Didn't feel judged   □ Able to catch up on sleep/eating/taking care of self

□ Freedom to stay connected to work/school/friends/etc. while getting extra support

Other: _____

11. What could have been improved during your stay at Afiya? (attach additional paper as needed)

_____

_____

_____

_____

12. If you want support in the future, would you choose Afiya over a traditional respite or hospital?

YES   **NO**   **NOT SURE**

Please tell us why:

_____

_____

_____

_____

13. Additional comments (If you would like to, please feel free to include a story of how Afiya has impacted you here. Although we try to keep this survey brief, longer stories are much appreciated!):

_____

_____

_____

_____

_____

_____

RE-AIM Interview Protocol

June 2012

Opening question: In your view, what is most important for me to get out of this interview?

Final question: Is there anything that you want to add about what we've discussed? Is there anything that I should have asked about that I didn't ask about?

Reach – Who Is Intended to Benefit from the Program

How would you describe the target population of 2nd Story? In your view, what percentage/ proportion of the target population will actually participate in the program? Are current participants representative of your target population? If so, how so? If not, how are they not?

Are there people who are excluded from participating in the program who could benefit from it?

How do you reach the target population? How does the program reach out to those who are most likely to benefit?

Effectiveness

In your own words, what is the goal of 2nd Story? Is 2nd Story achieving its goals in your view? Why or why not?

In your view, how could 2nd Story increase its effectiveness?

How might be improve on our efforts to assess 2nd Story's effectiveness?

Adoption

How can the mental health system better support the 2nd Story program? What kinds of organizational support are needed to sustain a program like 2nd Story?

What kind of short-term impact, if any, has 2nd Story had on the County Mental Health System as a whole? What might the long-term impacts be, if any?

Implementation

In your view, does 2nd Story run the way it was intended to run? If no, why not?

Can different levels of staff (manager, part-time, overnight) implement IPS successfully? Why or why not?

What parts of the program are flexible and adaptable, without decreasing efficacy? What parts of the program are not critical and not flexible?

Maintenance

In your view, does the program lead to lasting effects for individuals? Why or why not?

In what ways does the program follow-up with individuals once they leave 2nd Story? Is this adequate in your view? Why or why not?

Where do you see 2nd Story in one year? In five years?

2nd Story Evaluation: Guest Interviews
September 2013

Opening question: Tell me about your experience as a guest at 2nd Story.

Final question: Is there anything that you want to add about what we've discussed? Is there anything that I should have asked about that I didn't ask about?

House Atmosphere and Experience

How would you describe the atmosphere at the 2nd Story? How does the atmosphere at 2nd Story compare with other mental health programs you have been involved with?

What did you think about the day-to-day structure of the program? How about the level of flexibility? Was it too little, too much, or just right?

In what ways were staff members responsive to your interests and preferences for activities? How could they have responded better?

Can you think of a time you made a suggestion to change something in the house? How did that go?

Did you feel comfortable speaking openly in the common areas with staff at 2nd Story? Why or why not? In what ways did the physical layout of the house influence your experience at 2nd Story? What was it like for you to stay in a program with an open layout and no locked doors? What was it like for you to stay in a program with no staff office?

How would you describe how communication happens at 2nd Story? How is 2nd Story different than other organizations in terms of openness of communication, and the types of information that get shared between staff and guests? What is that like for you?

Relationship with Mental Health System

What other mental health services have you received? How was your stay at 2nd Story different than other mental health services you have received? How was it the same?

How is working with peers different than other mental health professionals that you've worked with? Did you like that all of the staff members were peers, or would you prefer working with non-peers? What's good or not so good about both?

What would you have done if this program hadn't been available to you? Would you have sought out other services instead? If so, what services?

What types of expectations did 2nd Story staff and providers have for you while you were at 2nd Story, if any? What was this like for you?

After 2nd Story

How is your life different now (if at all different) as a result of your experience at 2nd Story? One of the goals of 2nd Story is to support people in living the lives they want to live. In your experience,

did 2nd Story help you to live the life you want to live? In what ways did it help? In what ways could the program have done more to support you in this way?

What did you get out of being at 2nd Story? In what ways was the experience useful for you? In what ways could it have been more useful? Please provide examples if you can.

Some people come to 2nd Story to change old patterns of doing things. Would you say that the program helps people to do that? If so, can you give me an example of how the program helps with that?

Have you learned about any new Santa Cruz resources since being involved with the program? Do you feel connected to the Santa Cruz community? Is that different since you stayed at 2nd Story?

What kinds of supports (if any) have you started to use since you've been a guest?

Has your day-to-day functioning changed since you stayed at the program? If so, how is it different? In what ways, if any, has this program prepared you to go back to your day-to-day life?

Did staff work with you on any issues related to your housing? If so, how did that go?

Interactions with Staff

Describe a relationship that you have developed with a staff person. How did your relationship with this person change over time? How was this relationship unique compared with your relationships with other staff members?

What types of activities at the house (if any) helped you to develop relationships with staff? What activities (if any) made it harder to develop relationships?

How are your relationships with staff at 2nd Story similar or different from your relationships with other providers?

Can you think of a difficult conversation that you've had at the house? Please describe that conversation. What was it like for you?

Can you think of a situation when a staff member confronted or challenged you? Please describe that situation. What was that like for you?

Staff at 2nd Story have been trained to practice Intentional Peer Support. Are you familiar with that? In your view, what is Intentional Peer Support? Is this approach helpful for you? How could it be more helpful?

One important value of IPS is to accept where a person is at, even if that person is in a difficult place. In your interactions with staff, did you feel that they accepted where you were at? Can you give specific examples of that?

Did you have any conversations with staff about setting goals while you were at the house? If so, what were those conversations like?

Did you develop or work on any personal goals while you were at 2nd Story? If so, what was the process like for you? If not, why not? If you have any particular goals in mind, how were they developed? How do you know if you have met those goals?

Developing a Peer Community

How would you describe the group of people who spend time at 2nd Story (guests, staff, and visitors)? Do you feel that you belong or that you are a member of this group? Why or why not?

Do you identify as a peer now? Did you identify as a peer prior to coming to 2nd Story? How has your understanding of peers changed since you stayed at 2nd Story, if at all?

[For former guests] Have you returned to the program as a visitor, as a volunteer, or called the house phone to talk to staff since you left? If so, please describe a typical visit or call. Why did you decide to come back to the house or call the house?

Do you expect to stay connected to 2nd Story after you leave here, if at all? If so, how and why?

[For current guests] Have former guests come back to visit the house? Please describe a typical visit from a former guest.

Learning about the Program

How did you hear about the program?

Do you have any suggestions about how the program might get the word out to people who might benefit from staying at 2nd Story?

Pro-Active Interviews

Were you interviewed by staff before you came to the house? If so, please describe that experience. What did you learn during the interview? What do you think staff learned about you during the interview?

Were there other things that would have been helpful for staff to know before you came to 2nd Story? How might staff have gone about learning them?

TAY-Specific Questions (individuals for whom the 14-day limit was waived)

What has it been like to receive services from the adult mental health system for the first time? If you feel comfortable, please comment on your first impressions of the system as a whole, decisions about medications, and the "peer" identity [explain the concept of "peers" if necessary]. Has staying at 2nd Story made a difference in your experiences of the adult mental health system? If so, how? If not, how could programs like 2nd Story help people who are transitioning to the adult mental health system for the first time?

Did staff communicate with your mental health providers while you were staying at 2nd Story? If so, how did that go for you? How did you find out about this communication? What are the benefits to staff talking to your other providers? What are the drawbacks?

Did you, your providers, and 2nd Story staff create a specific plan while you were at 2nd Story (for example, a plan to regularly attend recovery-oriented meetings or participate in supported employment)? If so, how did that go for you? If you wanted to make changes to that plan, how did that go?

Recovery & Other Outcome Measures

Mental Health Recovery Measure (MHRM)©

(Young & Bullock, 2003)

Young, S.L., & Bullock, W.A. (2003). The Mental Health Recovery Measure. Available from University of Toledo Department of Psychology, (#918). Toledo, OH 43606-3390.

The goal of this questionnaire is to find out how you view your own current recovery process. The mental health recovery process is complex and is different for each individual. There are no right or wrong answers.

> *Please read each statement carefully, with regard to your own current recovery process. For each question, indicate the statement that best represents the way you feel:*
>
> *Strongly Disagree   Disagree   Not Sure   Agree   Strongly Agree*

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. I work hard toward my mental health recovery.					
2. Even though there are hard days, things are improving for me.					
3. I ask for help when I am not feeling well.					
4. I take risks to move forward with my recovery.					
5. I believe in myself.					
6. I have control over my mental health problems.					
7. I am in control of my life.					
8. I socialize and make friends.					
9. Every day is a new opportunity for learning.					
10. I still grow and change in positive ways despite my mental health problems.					
11. Even though I may still have problems, I value myself as a person of worth.					
12. I understand myself and have a good sense of who I am.					
13. I eat nutritious meals every day.					
14. I go out and participate in enjoyable activities every week.					
15. I make the effort to get to know other people.					
16. I am comfortable with my use of prescribed medications.					

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
17. I feel good about myself.					
18. The way I think about things helps me to achieve my goals.					
19. My life is pretty normal.					
20. I feel at peace with myself.					
21. I maintain a positive attitude for weeks at a time.					
22. My quality of life will get better in the future.					
23. Every day that I get up, I do something productive.					
24. I am making progress towards my goals.					
25. When I am feeling low, my religious faith or spirituality helps me feel better.					
26. My religious faith or spirituality supports my recovery.					
27. I advocate for the rights of myself and others with mental health problems.					
28. I engage in work or other activities that enrich myself and the world around me.					
29. I cope effectively with stigma associated with having a mental health problem.					
30. I have enough money to spend on extra things or activities that enrich my life.					

Client's Name: _____ Date: _____

Thank you for completing this measure.

The MHRM© was developed with the help of mental health consumers by researchers at the University of Toledo, Department of Psychology. This research was supported through a grant from the Ohio Department of Mental Health, Office of Program Evaluation and Research. For further information, please contact Wesley A. Bullock, Ph.D. at (419) 530-2721 or email: Wesley.bullock@utoedo.edu.

Recovery Markers Questionnaire

Second Story Peer-Run Respite Baseline and Follow-up Survey

Guest's County ID: _____

Interview Date: _____

Interviewer initials: _____

Interview Type:

○   Baseline

○   Follow-up

❐ Consents to let research team review protected health information

For each of the following questions, please indicate the answer that is true for you now.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	*Don't Know*	*Refused*
1. My living situation is safe and feels like home to me.	○	○	○	○	○	○	○
2. I have trusted people I can turn to for help.	○	○	○	○	○	○	○
3. I have at least one close mutual (give-and-take) relationship.	○	○	○	○	○	○	○
4. I am involved in meaningful productive activities.	○	○	○	○	○	○	○
5. My psychiatric symptoms are under control.	○	○	○	○	○	○	○
6. I have enough income to meet my needs.	○	○	○	○	○	○	○
7. I am not working, but see myself working within 6 months.	○	○	○	○	○	○	○
8. I am learning new things that are important to me.	○	○	○	○	○	○	○
9. I am in good physical health.	○	○	○	○	○	○	○
10. I have a positive spiritual life/connection to a higher power.	○	○	○	○	○	○	○
11. I like and respect myself.	○	○	○	○	○	○	○
12. I am using my personal strengths skills or talents.	○	○	○	○	○	○	○

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	*Don't Know*	*Refused*
13. I have goals I'm working to achieve.	O	O	O	O	O	O	O
14. I have reasons to get out of bed in the morning.	O	O	O	O	O	O	O
15. I have more good days than bad.	O	O	O	O	O	O	O
16. I have a decent quality of life.	O	O	O	O	O	O	O
17. I control the important decisions in my life.	O	O	O	O	O	O	O
18. I contribute to my community.	O	O	O	O	O	O	O
19. I am growing as a person.	O	O	O	O	O	O	O
20. I have a sense of belonging.	O	O	O	O	O	O	O
21. I feel alert and alive.	O	O	O	O	O	O	O
22. I feel hopeful about my future.	O	O	O	O	O	O	O
23. I am able to deal with stress.	O	O	O	O	O	O	O
24. I believe I can make positive changes in my life.	O	O	O	O	O	O	O

Which of the following statements is most true for you? (check only one)
O I have never heard of, or thought about, recovery from psychiatric disability
O I do not believe I have any need to recover from psychiatric problems
O I have not had the time to really consider recovery
O I've been thinking about recovery, but haven't decided to move on it yet
O I am committed to my recovery, and am making plans to take action very soon
O I am actively involved in the process of recovery from psychiatric disability
O I was actively moving toward recovery, but now I'm not because:
O I feel that I am fully recovered; I just have to maintain my gains
O Other (specify):
O *Don't know*
O *Refused*

Thank you for taking the time to complete this survey.

Appendix B: Interview Guide for Respite Directors

1. First, I wanted to ask you generally what you think about research and evaluation on peer programs. Do you think there are any benefits? *[Prompt: If so, what?]*

2. Can you tell me how many different evaluations or data collection efforts your respite has been involved in? These could be asking guests to fill out a survey for your funder, any reporting you have done, or more formal evaluation and research. *[Prompt: This would include any tracking of the number of people that use your respite or any information you use internally]*

3. *[AS applicable]* I'll now ask you some more detailed questions about your evaluation and data collection efforts separately.

4. Who was involved in carrying out the evaluation or collecting data?

5. *[If external]* What role did your respite staff play?

6. What kind of measures did you use? *[Prompt: Was there any qualitative interviewing, where people got to talk or write freely about their experience in their own words? Were there quantitative questions, where people completed a questionnaire? Did you only measure outcomes at the end of people's stay at the respite, or were they asked questions during their stay to understand the experience of the respite?]*

7. Can you describe the research design for me*? [Prompt: Were people interviewed or asked to complete a questionnaire at the beginning and end of their stay? Did you compare groups of people at any point? Were people randomly selected to be interviewed?]*

8. How did your organization and the evaluation team decide what methods to use?

9. What outcomes or impacts were you most interested in understanding?

10. Did you or the evaluation team create a logic model? *(If so, ask if LM can be sent.)*

11. If quantitative, what measures did you use? *(Ask if measures can be sent.)*

12. If qualitative, what type of approach was taken—focus groups, individual interviews? *(Ask if any interview or focus group guides can be sent.)*

13. How did the evaluation include respite guests and staff?

14. Did you have any concerns about the evaluation or challenges in carrying it out? What did you think could be done better?

15. *[If DID NOT do a formal evaluation]:* Why didn't you do a formal evaluation?

16. What do you think went well?

17. How has your organization used the results from the evaluation?

18. What about your experience with evaluating your program would you like to share with other respites who want to do evaluation and data collection?

19. Anything else you'd like to add?

Appendix C: Other Resources for Starting or Evaluating a Peer Respite

Existing Respites and Starting a Respite

Rose House Diversion Manual: A manual on creating a peer-run hospital diversion respite house, based on the experience of Rose House and the work of PEOPLE, Inc.

NEC Crisis Alternatives Page: A directory of peer-run and peer-operated alternatives compiled by NEC and other resources on crisis alternatives.

For Information About Formal Evaluations

Second Story, Santa Cruz, CA:
Human Services Research Institute, Cambridge, MA
Bevin Croft: bcroft@hsri.org

Hacienda of Hope and SHARE! Recovery Retreat, Lost Angeles, CA
University of California, San Diego
Todd Gilmer: tgilmer@ucsd.edu

Rose House, Albany, NY
The College of Saint Rose
Michael J. Bologna: bolognam@strose.edu

Keya House, Lincoln, NE
University of Nebraska
Alan Green: agreen@mha-ne.org

Afiya, Northampton, MA
University of Massachusetts
Jon Delman: jdelman@reservoircg.org

Cited Materials

Bola, J. R., & Mosher, L. R. (2003). Treatment of acute psychosis without neuroleptics: two-year outcomes from the Soteria project. *The Journal of nervous and mental disease, 191*(4), 219-229.

Bologna, M. J., & Pulice, R. T. (2011). Evaluation of a peer-run hospital diversion program: A descriptive study. *American Journal of Psychiatric Rehabilitation, 14*(4), 272-286.

Campbell-Orde, T., Chamberlin, J., Carpenter, J., & Leff, H. S. (2005). Measuring the Promise: A Compendium of Recovery Measures, Volume II. Cambridge, MA: The Evaluation Center @ HSRI.

Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer Support Services for Individuals With Serious Mental Illnesses: Assessing the Evidence. *Psychiatric Services*.

Creswell, J. W., Klassen, A. C., Plano Clark, V. L., & Smith, K. C. (2011). Best practices for mixed methods research in the health sciences. *Bethesda (Maryland): National Institutes of Health*.

Croft, B., Isvan, N., Chow, C., & Peterson, D. (2013). Service Use Implications of a Peer-Run Respite Program (Vol. 2013 Annual Exposition): American Public Health Association.

D'Agostino, R. B., & Rubin, D. B. (2000). Estimating and Using Propensity Scores With Partially Missing Data. *Journal of the American Statistical Association, 95*(451), 749-759.

Diehr, P., Yanez, D., Ash, A., Hornbrook, M., & Lin, D. Y. (1999). Methods for Analyzing Health Care Utilization and Costs. *Annual review of public health, 20*, 125-144.

Duan, N., Manning, W. G., Jr., Morris, C. N., & Newhouse, J. P. (1983). A Comparison of Alternative Models for the Demand for Medical Care. *Journal of Business & Economic Statistics, 1*(2), 115-126. doi: 10.2307/1391852

Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*(5), 531-540.

Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology, 42*(1), 135-144.

Hoot, N. R., & Aronsky, D. (2008). Systematic review of emergency department crowding: causes, effects, and solutions. *Annals of emergency medicine, 52*(2), 126-136. e121.

Johnsen, M., Teague, G., & Campbell, J. (2006). Assessing Consumer-Operated Services: Development and Characteristics of the Consumer-Operated Service Program Fidelity Assessment Common Ingredients Tool (COSP-FACIT) *Final Report of the COSP Multisite Research Initiative*. St. Louis, MO: Missouri Institute of Mental Health.

Lieberman, J. A., Dixon, L. B., & Goldman, H. H. (2013). Early detection and intervention in schizophrenia: a new therapeutic model. *JAMA, 310*(7), 689-690.

Mead S, Hilton D, Curtis L. (2001) Peer Support: A Theoretical Perspective. *Psychiatric Rehabilitation Journal, 25*(2):134.

Meleis, A. I. (1996). Culturally competent scholarship: Substance and rigor. *Advances in nursing science, 19*(2), 1-16.

Minkler, M., & Wallerstein, N. (2010). *Community-based participatory research for health: From process to outcomes*: John Wiley & Sons.

Ostrow, L., & Hayes, S. (2013). First Report of the National Survey of Mental Health Peer-Run Organizations: Characteristics nationwide. Baltimore, MD: Lived Experience Research Network.

Ostrow, L., & Leaf, P. J. (2014). Improving capacity to monitor and support sustainability of mental health peer-run organizations. *Psychiatr Serv, 65*(2), 239-241. doi: 10.1176/appi.ps.201300187

Rogers, E. S., Teague, G. B., Lichenstein, C., Campbell, J., Lyass, A., Chen, R., & Banks, S. (2007). Effects of participation in consumer-operated service programs on both personal and organizationally mediated empowerment: Results of multisite study. *population, 11*, 12.

Rosenbaum, P., & Rubin, D. B. (1983). The Central Role of the Propensity Score in Observational Studies for Causal Effects. *Biometrika, 70*(1), 41-55.

Rubin, D. B. (1997). Estimating causal effects form large data sets using propensity scores. *Annals of Internal Medicine, 127*(8), 757-763.

Seekins, T., & White, G. W. (2013). Participatory action research designs in applied disability and rehabilitation science: Protecting against threats to social validity. *Archives of physical medicine and rehabilitation, 94*(1), S20-S29.

Segal, S. P., Silverman, C. J., & Temkin, T. L. (2013). Self-Stigma and Empowerment in Combined-CMHA and Consumer-Run Services: Two Controlled Trials. *Psychiatric Services, 64*(10), 990-996.

. SPSS Version 22. (2013). Chicago: IBM.

Thomas, K. A., & Rickwood, D. (2013). Clinical and cost-effectiveness of acute and subacute residential mental health services: a systematic review. *Psychiatric Services, 64*(11), 1140-1149.

Viswanathan, M., Ammerman, A., Eng, E., Garlehner, G., Lohr, K. N., Griffith, D., . . . Lux, L. (2004). Community-Based Participatory Research: Assessing the Evidence: Summary.

Wallerstein, N., & Duran, B. (2008). The theoretical, historical, and practice roots of CBPR. *Community-based participatory research for health: From process to outcomes*, 25-46.