PEER OUTCOMES PILOT / HAVEN FOR HOPE

AUGUST 30, 2018

Recovery Oriented Service Provision and Individual Outcomes

Haven for Hope / San Antonio, Texas

The University of Texas at Austin
Texas Institute for Excellence in Mental Health
Steve Hicks School of Social Work

CONTACT

Texas Institute for Excellence in Mental Health
Steve Hicks School of Social Work
The University of Texas at Austin
1717 West 6th Street, Suite 335
Austin, Texas 78703

Phone: (512) 232-0616 | Fax: (512) 232-0617
Email: txinstitute4mh@austin.utexas.edu
sites.utexas.edu/mental-health-institute

PROJECT LEADS / AUTHORS

Wendy Kuhn, MA
Stacey Stevens Manser, Ph.D

ACKNOWLEDGEMENT

This work is funded through a contract with the Texas Health and Human Services Commission (HHSC). The contents are solely the responsibility of the authors and do not necessarily represent the official views of the HHSC.

Recommended Citation: Kuhn, W. and Stevens Manser, S. (2018). Recovery Oriented Service Provision and Individual Outcomes. Texas Institute for Excellence in Mental Health, Steve Hicks School of Social Work, University of Texas at Austin.

Contents

Background

History of the Recovery Movement

Prior to the 1940s, advocates for the ideism of mental health and substance use recovery were independent and sparse. From midcentury on, the confluence of various organizations, publications, the civil rights movement and individual leaders drove the movement, fighting for the idea that people can and do recover. The recovery movement transcended the boundaries between mental health, substance use, and homelessness system silos as pioneers such as Howie the Harp forged advocacy groups like the *Mental Patients Liberation Front* in the 1970s, advocating for both mental health and homelessness issues.

From the 1970s on, supporters of the *Consumer/Survivor/Ex-Patient Movement* advocated for policy and system change, civil rights, humane treatment, and education that people do recover. The value of lived experience and adoption of principles of recovery emerged from the movement and began shaping the public behavioral health service system to be more recovery oriented. This would become known as the *Recovery Movement*, laying the foundation for a new recovery-oriented system and peer support workforce. Peer support providers are people in recovery employed to share their experiences to promote the recovery of others impacted by mental health conditions. However, it wasn't until the 1990s that peers were professionalized into paid positions at mental health provider organizations.

Recovery has since become the new paradigm for behavioral healthcare in the United States. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2015) offers a definition of recovery that encompasses both mental health and substance use: "a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential." The President's New Freedom Commission on Mental Health (2003) named recovery the organizing principle for the transformation of mental health services and the expected outcome of mental health services and Recovery Oriented Systems of Care (ROSC) as the infrastructure to effectively address substance use (SAMHSA, 2010).

The case for peer support services

Peer support providers have emerged as a new workforce on the landscape of this shifting system. Research that supports the provision of mental health peer support services is promising. First generation meta-analyses and systematic reviews suggest that peer support services may influence certain recovery outcomes including: reduced inpatient service use, improved relationship with providers, better engagement with care, higher levels of empowerment, higher levels of patient activation, higher levels of hopefulness for recovery (Chinman, George, Dougherty, Daniels, Ghose, Swift, & Delphin-Rittmon, 2014; Davidson et al., 2018), wellness self-management, healthcare engagement (Cabassa, Camacho, Velez-Grau, & Stefancic, 2016), reduced length of stay, reduced crisis and emergency service use, improved social relations, greater client satisfaction with service provision (Pitt et al., 2013), and greater quality of life (Bellamy, Schmutte, & Davidson, 2017; Fuhr, Salisbury, De Silva, Atif, Ginneken, Rahman, & Patel, 2014). Recent research also suggests that peer support may decrease substance use (Mangrum, Spence, Nichols, & Peterson, 2017; Felton et al., 1995), decrease homelessness, improve general health (Corrigan et al., 2017), reduce hospital readmission (Mangrum et al., 2017; Scanlan, Hancock, & Honey, 2017), and increase self-sufficiency (Mahlke et al., 2017).

With these various aspects of a person's recovery that peer services can impact, and the variety of different programs through which that impact occurs, the need to understand the mechanisms of action that make these peer relationships so powerful remains.

The power of lived experience and self-disclosure

Research suggests that peers may influence recovery outcomes through services such as supporting recovery planning, providing group peer support (Chinman et al., 2015), assisting with Wellness Recovery Action Planning (WRAP; Jonikas et al., 2013), providing one-to-one peer support (Mahlke et al., 2017; Rogers et al., 2016), practical daily life support, mediating with other providers, support in understanding crisis (Mahlke et al., 2017), and providing independent living skills training (Salzer et al., 2016). While these types of services could generally be delivered by different types of providers other than peer specialists, peers are better equipped to "to inspire hope, destigmatize mental illness, and empathically support" the people they serve because of their personal lived experience with the impact of mental illness and of receiving services (Oh & Rufener, 2017). The provision of practical supports, role modeling, mentoring, social opportunities, and emotional support, when ***provided through the normalizing relationship with someone who has shared experiences*** may be the most effective aspect of the peer relationship (Gidugu et al., 2015). However, lived experience in and of itself doesn't necessarily result in quality services or better outcomes. The behavioral health field still needs to understand what impacts the ability of a provider with lived experience to engage with a person receiving services. More pragmatically, what are those factors that the organization can influence, through training, technical assistance, policy, and/or practice, which can help or hinder the effectiveness of peer services?

Factors known to limit the effectiveness of peer services

Not surprisingly, those factors which impact peer provider retention and the effectiveness of peer services align with practices that affect peer provider integration within an organization.

- **Personal trauma history and trauma-informed workplace** – An organizational environment which is not trauma-informed and trauma-responsive is a contextual risk factor for secondary traumatization (ST), compassion fatigue, and burnout of staff. ST *is a trauma-related stress reaction and set of symptoms resulting from exposure to another individual's traumatic experiences rather than from exposure directly to a traumatic event*. ST contributes to turnover and employee attrition, making it a significant organizational issue (SAMHSA, 2014). Peer providers, who are likely to have personal trauma experience by the very nature of their role, are most often working in direct service roles with people that have high prevalence of trauma history themselves. The interaction of these factors is more likely to result in ST and subsequent burnout of peer staff. Trauma history as a personal characteristic not only affects peers, but all types of staff including those providing clinical services and those working in administrative roles. It follows that organizational culture, policies, and practices which can mitigate risk for ST also impact the ability of providers to engage with people. When staff experience ST, they are more likely to perform job duties ineffectively, experience psychological or emotional impairment (SAMHSA, 2014), terminate employment, use more sick days, and/or file more worker's compensation claims (Maltzman, 2011), all of which have a negative impact on recovery outcomes of people receiving services.

- **Organizational culture** – A culture in which pervasive stigma is placed upon peer specialists and people receiving services is a challenge to peer integration and retention, thereby limiting their

effectiveness. The organizational culture, or observed norms, beliefs, and expectations, has the potential to ameliorate employee ST and burnout through normalization of negative emotions in response to ST and building awareness through training and continuing education (Killian, 2008; Maltzman, 2011; Sansbury, Graves, & Scott, 2015).

- **Supervisory alliance** - Supervisors' ability to support peer role fidelity and self-care policies may be limited either by conflicting organizational policies and funding requirements or by inadequate training/knowledge. Without critical supervisor support, peer providers are limited in their ability to perform truly peer roles. Further, the supervisor's awareness of an employee's risk for ST and responsiveness, plays a role in preventing and mitigating ST and burnout. Supervisors can influence organizational factors to prevent ST and burnout including support during critical incidents, proactive supervision techniques, and sanctioning time for self-care at work (Maltzman, 2011; Warren, Morgan, Morris, & Morris, 2010).

- **Organizational and supervisory practices** – High caseloads and overwork are barriers to effective job performance in any role, especially behavioral health providers. Employee-supportive practices that limit workload (hours and caseload) and case management techniques, such as limiting the number of people with complex traumas on any one caseload, can reduce employee risk for ST and burnout (Williams, Helm, & Clemens, 2012; Killian, 2008; Maltzman, 2011; Bober & Regehr, 2006).

Even programming designed with the best intentions may result in sub-optimal outcomes if it fails to address such contextual factors, all of which impact providers' ability to engage with people they serve. The effectiveness of peer services, or any services, for improving recovery outcomes depends in part on the organization's support for providers with lived experience – both culturally and in policy and practice. This evaluation not only asks whether peer support services are effective, but it also asks: *how effective can peer services be within an organizational context?*

Purpose

The Texas Health and Human Services Commission (HHSC) contracted with the Texas Institute for Excellence in Mental Health (TIEMH) to design and implement an evaluation plan to assess the effectiveness of peer support services, specifically the outcomes of people receiving peer-provided mental health services in Texas. To do this, researchers collaborated with the leadership team at Haven for Hope to guide study design, data collection and analysis. Haven member outcomes were examined in the Jail Outreach (JO) and Permanent Supported Housing (PSH) programs specifically. Findings may be used to guide current and future program development and provide important insights into the outcomes of peer support services at Haven for Hope.

Evaluation questions and context

Keeping with the purpose of the pilot, of primary interest were the outcomes of members receiving services in the two peer-driven programs – Jail Outreach (JO) and Permanent Supportive Housing (PSH). Available outcome data which was theoretically related to, and which the evidence base for peer services has indicated may be related to, recovery included: acuity, housing status, justice involvement, employment history, service engagement, and return to homelessness following program participation.

> Question 1: How did member outcomes change over the course of program participation, and were changes related to interaction with peer staff?

The pilot leadership team at Haven for Hope was also interested in understanding what affects provider ability to engage, including recovery knowledge and attitudes, as these factors were hypothesized to influence member recovery outcomes.

> Question 2: What staff characteristics (e.g., lived experience, stigma, attitudes, recovery knowledge, etc.) may affect recovery outcomes for members, and how might organizational factors moderate this relationship?

To answer these questions, both the framework of the specific programming mechanics and the organizational context at Haven for Hope must be considered.

Haven for Hope

Haven for Hope is a non-profit organization which has been providing services to people experiencing homelessness since 2010, including both individuals and families. The organization has mixed funding streams ranging from private donors to the federal government. Haven for Hope offers a wide-array of services in-house and also partners with over 60 non-profit organizations on campus to provide additional services to Haven "members." The campus spans 23 acres in downtown San Antonio and offers dormitories for 850 people as well as safe temporary shelter for non-members who choose not to engage in other services. Services include detox and sobering, medical and dental services, peer support, case management, psychotherapy, spiritual services, meals, a post office, a pet kennel, employment readiness, educational support, and many more. Haven for Hope's model promotes personal "transformation" for members, adopting the title of "transformational campus." While Haven for Hope requires its members to be drug- and alcohol-free while on campus receiving services, it also provides programs under the "housing first" model, which espouses that people should be housed *first*, without any requirements for sobriety, engagement in certain services, or completion of other requirements. The PSH program is one of these housing first programs offered at Haven for Hope.

Permanent Supportive Housing Program

The PSH program provides support for and connects people with resources needed for the self-sustainability required to maintain independent housing. People are housed according to the *housing first* model of care, meaning that there is no requirement for them to receive any type of specific service, or to abstain from substance use, before their need for housing is met. Once housed by the Haven to Home program, they are immediately referred to PSH, although, there is normally a waitlist to enroll. Each person works with a team of two staff including a case manager and a peer support provider. A total of 10 staff provide direct care services for PSH (5 case managers and 5 peer providers), and each team has a caseload of approximately 25 people. The peers and case managers on these teams have very similar roles, but the peers use their lived experience to engage with people. Anecdotally, this engagement is often the key difference between successful long-term housing and returning to homelessness. To remain in the program, people must continue to meet with their provider teams during reoccurring home visits.

PSH provides whatever types of services or referrals are needed, including but not limited to, financial assistance for housing, peer support, crisis support, education on life skills needed to remain in housing, and connection to external resources and other concrete supports. A SPDAT must be completed within the first 30 days of enrollment in PSH, and is updated every three months. Also updated every three months is a Person Centered Plan (PCP), which serves as the reference point for working to support the goals of the person. People with more

needs meet more frequently with the team (about once weekly) and people with fewer needs to remain self-sustaining meet less frequently (from bi-weekly to once per month). The peer-case manager teams provide individually-tailored services to people for as long as it takes to graduate from the program. Once people graduate, the team checks in at 30 and 90 days post-graduation; people then exit the program or re-open enrollment if needed.

Jail Outreach Program

The JO program focuses on connecting people who have recently been released from incarceration with the resources needed to remain in the community and maintain independent housing. The JO program is completely peer run, with four full-time peer providers on staff. These peers provide peer services (group and individual), case management services, and housing assistance to approximately 52 people. The team does not split the caseload, meaning that all four peers provide services to all people enrolled in the program, with rare exception. Referrals to JO come from Bexar county pre-trial services and University Health System (UHS) in San Antonio. Previously, the JO program also accepted non-contractual referrals, but now only accept up to 40 referrals from pre-trial and 20 referrals from UHS, for a total capacity of 60. There is no waitlist for JO. Peers report that the length of stay in the program generally ranges from approximately five days to six months, with an average estimated to be about four months. Sometimes people exit before adjudication if restrictions have been lowered. Once adjudicated, people may remain enrolled for a maximum of 90 days.

Most services are provided at Haven for Hope; the open-door policy encourages drop-ins for as-needed services by making snacks and coffee available in the community office at intake. This flexible schedule is essential to the success of the program because people awaiting adjudication often have many obligations to meet within the criminal justice system. Generally, peers first make contact with people while they are still incarcerated, providing information about the voluntary program, obtaining as much information as is needed to complete a VISPDAT, and doing person-centered planning. Anecdotally, the peer approach to the interview makes all the difference in truly engaging the person during an otherwise stressful and public review of personal information. In the JO program, peers begin a housing plan with people once they are in stable employment, although some participate in other housing programs (e.g., at the Center for Healthcare Services, sober living, Oxford House, etc.). At this time, JO has not referred anyone to other teams at Haven, nor has anyone been intentionally referred to the PSH program.

Both the PSH and JO programs support a person-centered model of care and expected recovery-oriented outcomes, mainly supporting peoples' integration into the communities of their choosing on their own terms. However, the peer providers in both programs are providing a mix of peer services and traditional case management services, necessitated by the structure of the programs and contractual requirements, which may limit the ability to determine how outcomes are impacted specifically by peer support – over and above recovery-oriented services.

Methods

Mixed methods approach

This pilot employed multimethod data collection techniques including 1) extracting existing records data from the Homeless Management Information System (HMIS) at Haven for Hope, 2) administering an online survey to Haven for Hope staff, and 3) interview of peer support staff working in the two programs of study at Haven for Hope. While a primarily quantitative approach was taken to answering the evaluation questions, a qualitative approach was needed to more comprehensively describe the program settings, experiences of, and job roles of the peer specialist staff. This type of detailed information is essential to report in any investigation of the outcomes of peer support services because of the impact and constraints that the organizational and program context have on this new workforce that is emerging in the midst of a paradigm shift in the larger mental health system.

Member data

Recovery outcome measures were selected based on review of the literature of the outcomes and effectiveness of peer-provided services, expert discussion, and availability of data in HMIS maintained by Haven for Hope.

Haven for Hope maintains member data with the HMIS database, a web-based software system used to coordinate care among 44 direct service provider agencies in the San Antonio Continuum of Care (CoC; Haven for Hope, 2018). The CoC in San Antonio / Bexar County is the South Alamo Regional Alliance for the Homeless (SARAH). The Data Standards for HMIS are published by the U.S. Department of Housing and Urban Development Housing and Urban Development (HUD) for use by all HUD-funded providers serving people who are receiving homeless assistance services as well as other non-HUD funded providers who opt to use the system to coordinate care in their communities. The types of data that are collected and the way they are operationalized and reported are consistent across all HUD CoCs of homeless assistance providers, potentially allowing for comparison of outcomes with other communities. Haven for Hope collects the minimum dataset required to meet HUD standards but also collects additional information to support their programs.

Measures

Researchers collaborated with the Haven for Hope leadership team for the pilot to finalize selection of the member recovery outcome constructs/measures:

- *Length of Stay* is measured in days and is defined by date of program entry and date of program exit.
- *Substance Use/Mental Health Diagnosis* is collected qualitatively at intake.
- *Housing Status and Length* is measured by number of episodes and months spent without housing in the past three years, as well as current housing status and destination after program exit.
- *Justice Involvement* is measured by the existence of any current outstanding or recent legal issues which may result in fines, incarceration, and/or community service, or historical issues which were resolved through fines, incarceration, and/or community service.
- *Employment History* describes whether the individual obtained employment before, during, or after enrollment in the employment readiness program, and also whether that employment ended before, during, or after enrollment.
- *Education Status* (diploma, GED, degree or other)

- *Service Engagement* is measured by services received, including type, date, and provider name.
- *Recidivism* is measured by the presence of an interaction in the HMIS system 12 months post enrollment closing.
- *Demographic Information* includes age in years, ethnicity, race, gender, and residence prior to becoming a Haven member.
- *Acuity* is measured by Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) score. While there is no clinical significance for VI-SPDAT, this triage tool is designed to complement existing clinical approaches by providing a more detailed picture of client's acuity. The VI-SPDAT is a brief 7-minute survey that can be conducted to quickly determine whether an individual/family has high, moderate, or low acuity by examining factors of current vulnerability and future housing stability. An adult may be administered either the family version of the assessment or the single adult version, depending upon whether they are seeking services with other family members (both adults and children).

  Research suggests that the SPDAT tool, on which the briefer VI-SPDAT is structured, improves housing outcomes when the tool is used. Haven for Hope uses this evidence-based tool to assist with prioritizing which clients should be given a full SPDAT assessment. As a requirement for enrollment into services, all clients receive an assessment, which includes the VI-SPDAT, conducted at intake. Once settling onto campus and depending on the VI-SPDAT score, will then receive a full SPDAT assessment every 90 days. The VI-SPDAT for single adults total possible score ranges from 0 to 17, whereas the version for families total possible score ranges from 0 to 22, reflecting additional items related to the family unit. The following criteria to use to tool for intervention prioritization (Table 1):

Table 1. Scoring criteria for intervention prioritization using the VI-SPDAT

Type	Score range	Acuity	Recommendation
Individual	0 – 3	Low	No housing intervention
	4 – 7	Moderate	Assessment for Rapid Re-Housing
	8 - 17	High	Assessment for Permanent Supportive Housing/Housing First
Family	0 – 3	Low	No housing intervention
	4 – 8	Moderate	Assessment for Rapid Re-Housing
	9 - 22	High	Assessment for Permanent Supportive Housing/Housing First

Repeated measures of *acuity* - In addition to VI-SPDAT, item and domain scores on the full SPDAT assessment complement the acuity measure completed upon enrollment. Members who are deemed to be *moderate* and *high* service level from the VI-SPDAT, are administered an initial full SPDAT. This is completed within 30 days of enrollment onto campus, and guides placement into housing programs. PSH consists of individuals deemed to be at a high service level on the SPDAT (score 35-60). When clients move into housing with PSH, they are required to receive a new SPDAT within 30 days of exit from campus and move into housing. Following that, they receive an updated SPDAT every 90 days while enrolled in the program. The overall SPDAT score is what informs the level of intervention needed, whereas the individual domains more specifically inform person centered planning.

Staff survey

An online survey was developed with input from leadership staff providing guidance. Survey items measured demographic information, lived experience, attitudes / stigma toward people with mental health issues, and knowledge of recovery in both mental health and substance use recovery. See Appendix XX for the survey items and response choices. The survey was hosted on Qualtrics® online survey platform. A total of 276 email invitations

to complete the survey were sent to staff, including paid staff and Social Work Interns. The survey was open for response for two weeks, and a reminder email was sent one week prior to closure.

Measures

Researchers collaborated with the Haven for Hope leadership team for the pilot to finalize selection of staff survey measures:

- *Job Title*
- *Program and Department of employment*
- *Duration of Employment at Haven for Hope*
- *Designations/Certifications/Licensures held*
- *Demographic Information*
- *Lived Experience*
- *Knowledge, attitudes, and beliefs (stigma) about mental health and substance use recovery*

Beliefs about recovery

To assess staff knowledge and attitudes toward recovery oriented practices, the survey included a revised version of the Recovery Knowledge Inventory (RKI) instrument (Bedregal, O'Connell, & Davidson, 2006), which measures four domains of understanding about mental health and substance use recovery: 1) roles and responsibilities in recovery, 2) non-linearity of the recovery process, 3) the roles of self-definition and peers in recovery, and 4) expectations regarding recovery. The instrument was presented twice in the survey, in two semantically different versions: one measuring beliefs about mental health recovery and one measuring beliefs about substance use recovery. The instrument has a Likert-style response format ranging from 1 *(strongly disagree)* to 5 *(strongly agree)*. A lower score on the RKI indicates less recovery knowledge.

Stigma

To measure the stigma of helping professionals and students toward people with mental health issues, the survey included a revised version of the Mental Illness: Clinician's Attitudes Scale (MICA *version* 4). Because the researchers conduct all work with the imperative to use language consistent with a recovery paradigm (as opposed to illness), wording of the MICA-4 instrument was revised slightly (e.g., instances of the term "mental illness" were replaced with "mental health issues"). The authors of the original scale did not grant permission for the researchers to use the MICA-4 with these language revisions, although the instrument is non-proprietary. Thus, this report will refer to the scale used as the MICA-TIEMH revised (MICA-TR). The revised instrument has a 6-point Likert-style response format ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). A lower score (out of 96 total scale points) on the MICA-TR indicates a more negative attitude / greater stigma toward mental illness.

Results

Member data

Permanent Supportive Housing program

Data was collected for everyone ever enrolled in PSH since July 2014, the date that the PSH program began at Haven for Hope. Between July 1, 2014 and August 2, 2018, 2,223 adults were enrolled into the Permanent Supportive Housing program. Thirteen of those people were enrolled in JO at a later date.

Demographics

PSH enrollees tended toward older age ranges and the majority reported male gender. Most were white, non-Hispanic, and had a high school diploma or some college education (see Table 2 and Figures 1 - 5).

Table 2. Demographic information of PSH enrollees

		N (%)
Age	18 to 24	140 (6.3)
	25 to 34	424 (19.1)
	35 to 44	455 (20.5)
	45 to 54	565 (25.4)
	55 and older	639 (28.7)
Gender	Female	907 (40.8)
	Male	1308 (58.8)
	Trans Female (MTF or Male to Female)	7 (0.3)
	Trans Male (FTM or Female to Male)	1 (<0.1)
Race	American Indian or Alaska Native	13 (0.6)
	Asian	13 (0.6)
	Black or African American	634 (28.5)
	Multi-Racial	24 (1.1)
	Native Hawaiian or Other Pacific Islander	9 (0.4)
	White	1521 (68.4)
	Other	3 (0.1)
	Not reported / Not collected	6 (0.2)
Ethnicity	Hispanic or Latino	850 (38.2)
	Non-Hispanic or Latino	1368 (61.5)
	Not reported / Not collected	5 (0.2)
Education	Less than 12th grade	63 (8.6)
	High School Diploma / GED	322 (38.8)
	Some college	164 (22.5)
	Associate's degree	30 (4.1)
	Bachelor's degree	68 (9.3)
	Graduate degree	4 (0.5)
	Not reported / Not collected	78 (10.6)
	Missing	1493

Figure 1. Age ranges of PSH enrollees

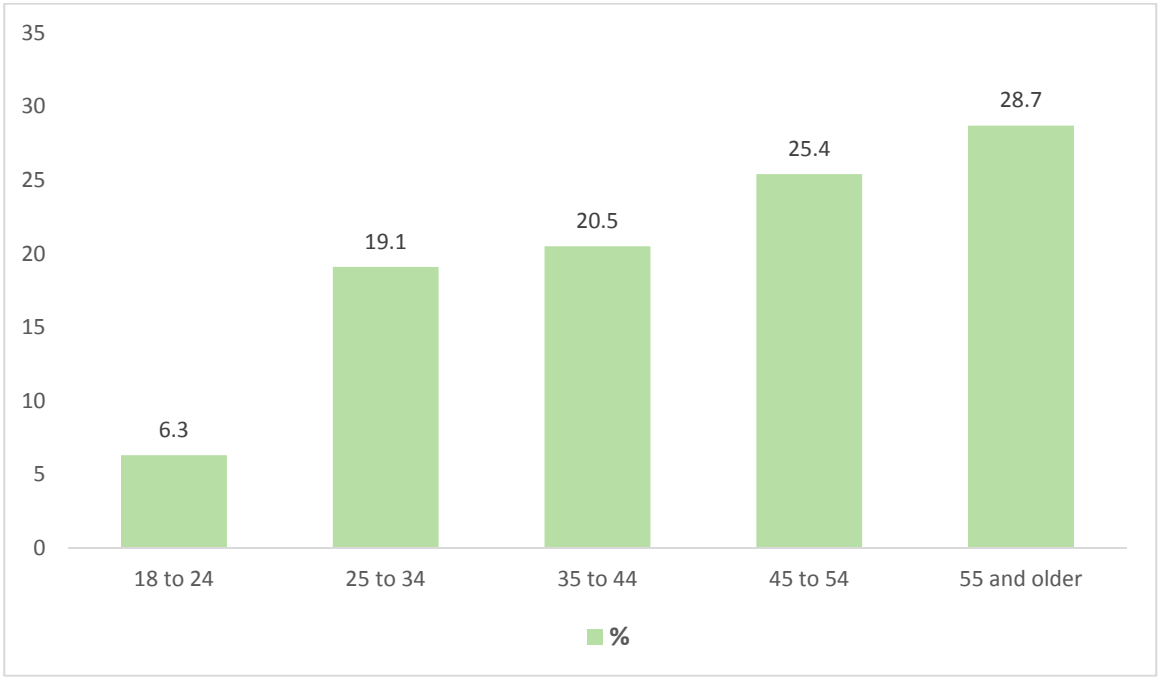


Figure 2. Gender of PSH enrollees

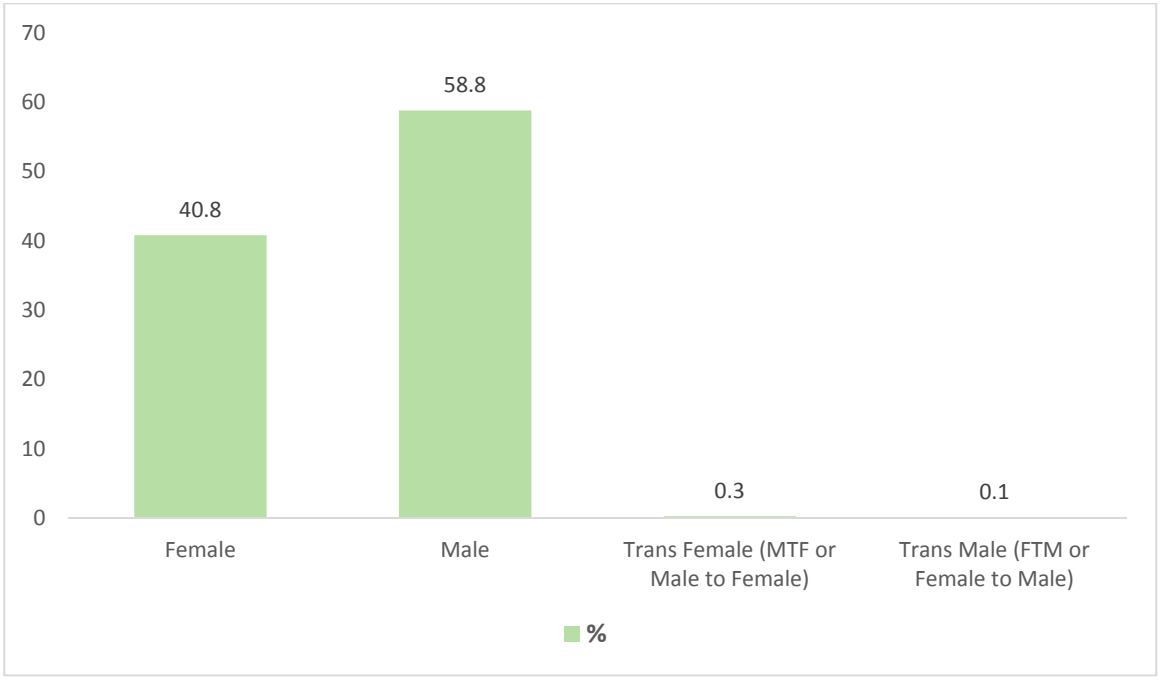


Figure 3. Race of PSH enrollees

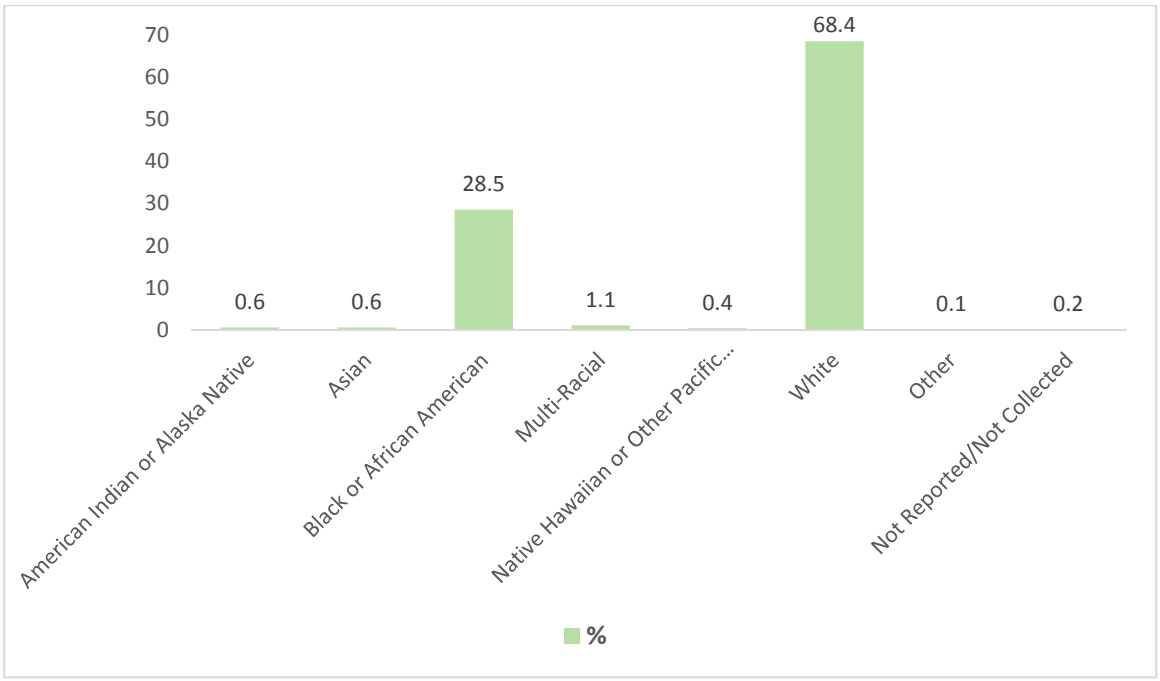


Figure 4. Ethnicity of PSH enrollees

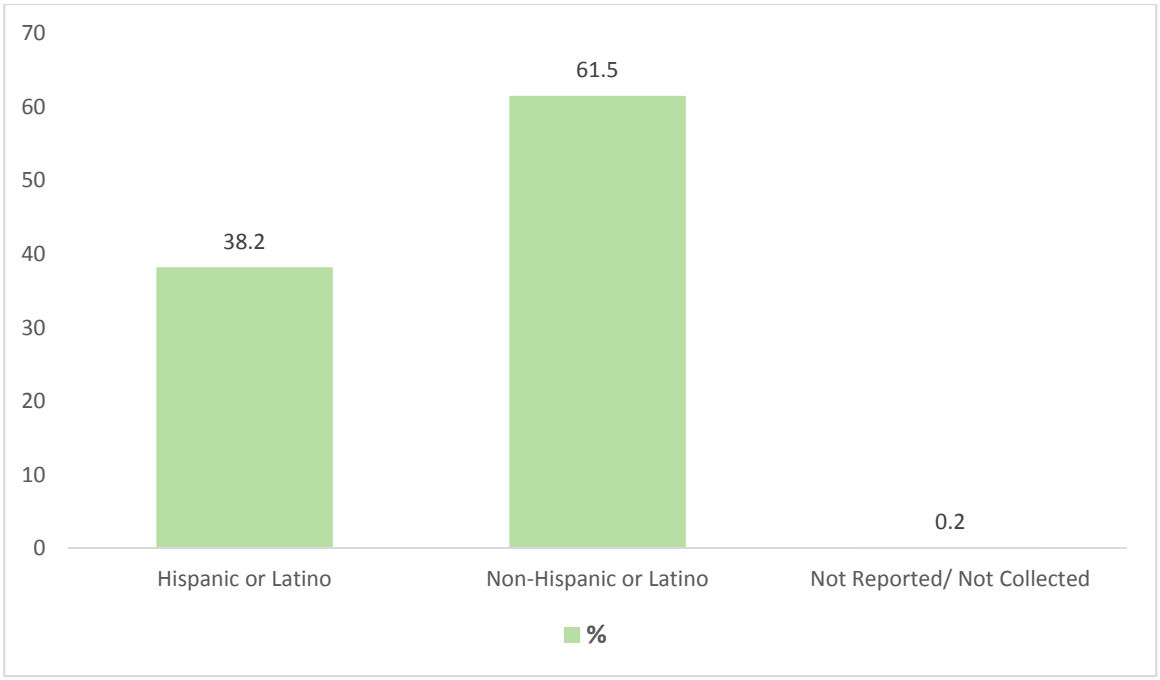
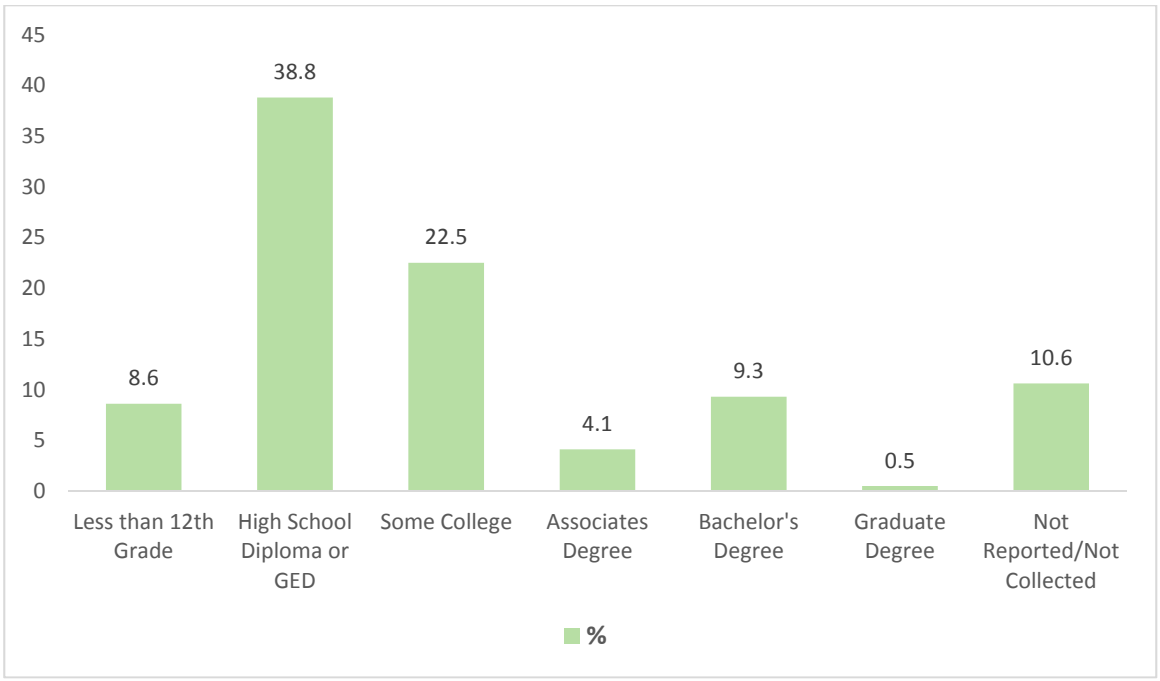


Figure 5. Educational Status of PSH enrollees



History of homelessness

Most PSH enrollees reported having had at least one homeless episode in the past three years, with one quarter reporting four or more episodes. About half reported having spent more than one year experiencing homelessness out of the past three years (See Tables 3 - 4 and Figures 6 - 7).

Figure 6. Number of homeless episodes in the past three years of PSH enrollees

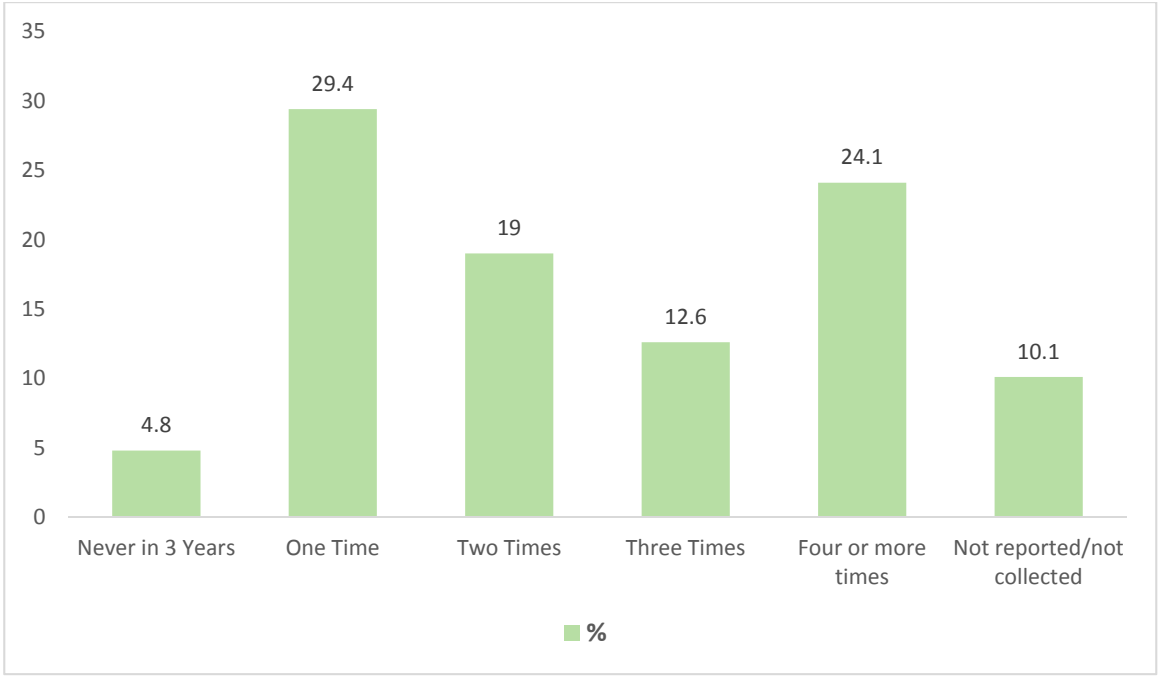


Table 3. Number of homeless episodes in the past three years of JO enrollees

Number of episodes	N (%)
Never in 3 years	86 (4.8)
One Time	522 (29.4)
Three Times	224 (12.6)
Two Times	337 (19.0)
Four or more times	428 (24.1)
Not reported / Not collected	179 (10.1)
Missing	447

Figure 7. Number of months experiencing homelessness in the past three years for PSH enrollees

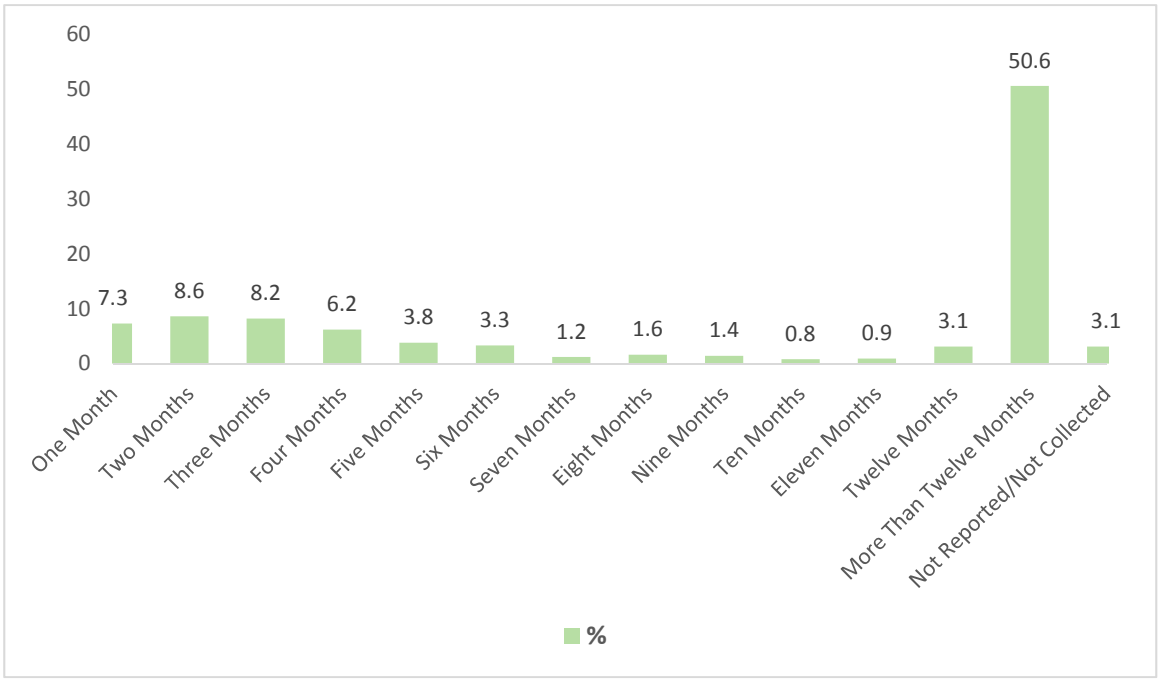


Table 4. Number of months experiencing homelessness in the past three years of JO enrollees

Number of months	N (%)
One Month (this time is the first month)	89 (7.3)
Two months	104 (8.6)
Three months	100 (8.2)
Four months	75 (6.2)
Five months	46 (3.8)
Six months	40 (3.3)
Seven months	14 (1.2)
Eight months	20 (1.6)
Nine months	17 (1.4)
Ten months	10 (0.8)
Eleven months	11 (0.9)
Twelve months	38 (3.1)
More than twelve months	615 (50.6)
Not reported / Not collected	37 (3.1)
Missing	1007

Average length of enrollment (length of stay)

Average length of enrollment could only be analyzed for those members who had already exited the program at the time of data collection and not for those with active enrollment. Members are enrolled into the PSH program on the day that they are housed. Valid length of stay ranged from 0 to 1,418 days (n=1,651). Those with a length of stay of zero days (n=4) were excluded from analysis. The average length of stay in the PSH program is approximately 340 days, or just under a year (M(SD) = 339.4 (249.5); n=1,647). This average is heavily influenced by a large cohort whose enrollment ended at the one-year mark (day 365-366; n=301).

Services

Members enrolled in the PSH program received services provided by Haven for Hope before, during, and after enrollment in the program. The service data timeframe for each individual extends from point of intake / enrollment at Haven for Hope through either 1) the day the data was extracted or 2) the date of graduation (if already graduated) plus any follow-ups available up to 90 days after graduation.

For this analysis, only services received during the period of program enrollment and that are most closely tied to program purpose and goals are presented. Of these, the most frequently provided direct services were case/care management, life skills training, peer support, and home visits from either case managers or peer support providers (Table 5).

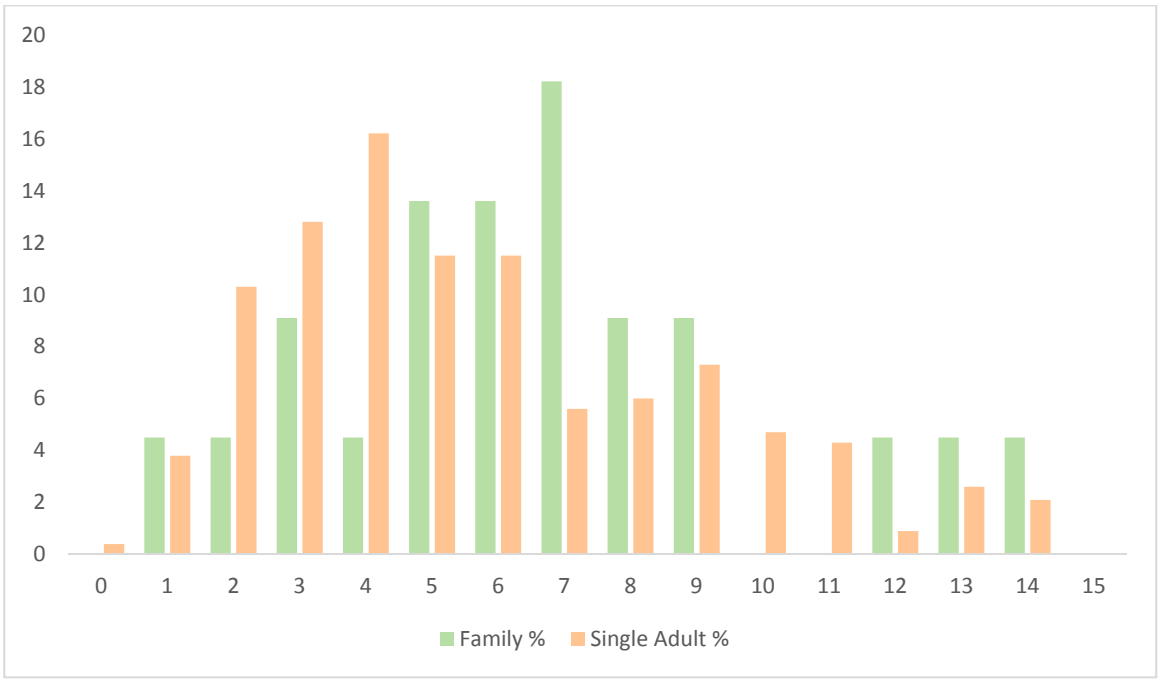
Table 5. Most frequent direct services provided during PSH enrollment period

Type of service	Number of services provided to all enrollees
Case/Care Management	19,682
Personal Enrichment/Life Skill	9,911
Peer Support Contact	4,496
Peer Support Home Visit	4,366
Case Manager Home Visit	4,080

VI-SPDAT

Preliminary analyses were conducted for the VI-SPDAT total score. Only scores belonging to the VI-SPDAT assessment conducted at first enrollment into the PSH program are presented (n = 256). Scores from other VI-SPDAT assessments conducted for different enrollments are not presented. The average total score for those completing the version for families fell in the moderate acuity range (M (SD) = 6.7 (3.3); n = 22; min = 1; max = 14). Most individuals for whom VI-SPDAT enrollment scores are available completed the version for single adults; the average score for this group also fell into the moderate acuity range (M (SD) = 5.7 (3.2); n = 234; min = 0; max = 14). Distribution (% of people) across total scores by assessment type are presented in Figure 8.

Figure 8. Distribution of VI-SPDAT total score by assessment type



Jail Outreach program

Data was collected for everyone ever enrolled in JO since November 2014. Between November 6, 2014 and August 6, 2018, 1,336 people were enrolled into the Jail Outreach Program. Thirty-eight of those people were enrolled in PSH at a later date.

Demographics

JO enrollees were approximately normally distributed across adult age ranges, with a majority being between the ages of 25 and 44, and reported gender was approximately split equally between male and female (with three people reporting trans female gender). Most were white, non-Hispanic, and had some college education or a college degree (see Table 6 and Figures 9 - 13).

Table 6. Demographic information for JO enrollees

		N (%)
Age	under 18	1 (0.1)
	18 to 24	189 (14.1)
	25 to 34	463 (34.7)
	35 to 44	379 (28.4)
	45 to 54	235 (17.6)
	55 and older	69 (5.2)
Gender	Female	660 (49.4)
	Male	673 (50.4)
	Trans Female (MTF or Male to Female)	3 (0.2)
	Trans Male (FTM or Female to Male)	0 (0.0)
Race	American Indian or Alaska Native	9 (0.7)
	Asian	2 (0.1)
	Black or African American	193 (14.4)
	Multi-Racial	21 (1.6)
	Native Hawaiian or Other Pacific Islander	2 (0.1)
	White	922 (69.0)
	Other	3 (0.2)
	Not reported / Not collected	184 (15.5)
Ethnicity	Hispanic or Latino	557 (41.7)
	Non-Hispanic or Latino	598 (44.8)
	Not reported / Not collected	181 (13.6)
Education	Less than 12th grade	6 (22.2)
	Some college	8 (29.6)
	High School Diploma / GED	0 (0)
	Associate's degree	6 (22.2)
	Bachelor's degree	3 (11.1)
	Graduate degree	0 (0)
	Not reported / Not collected	4 (14.8)
	Missing	1309

Figure 9. Age ranges of JO enrollees

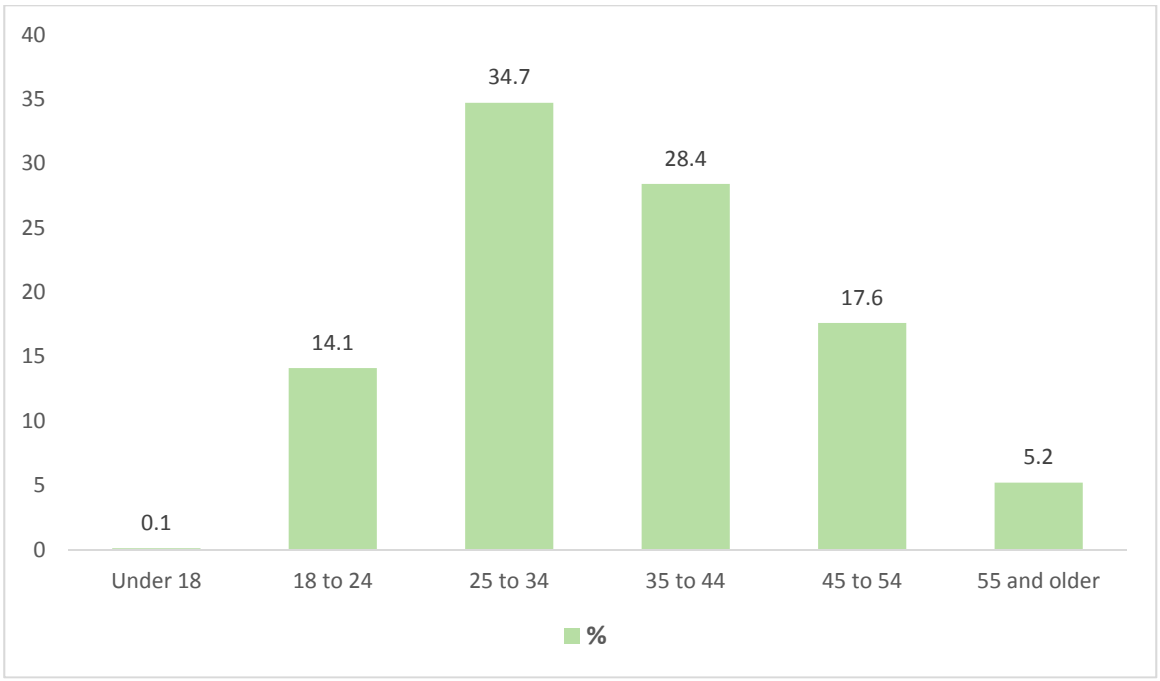


Figure 10. Gender of JO enrollees

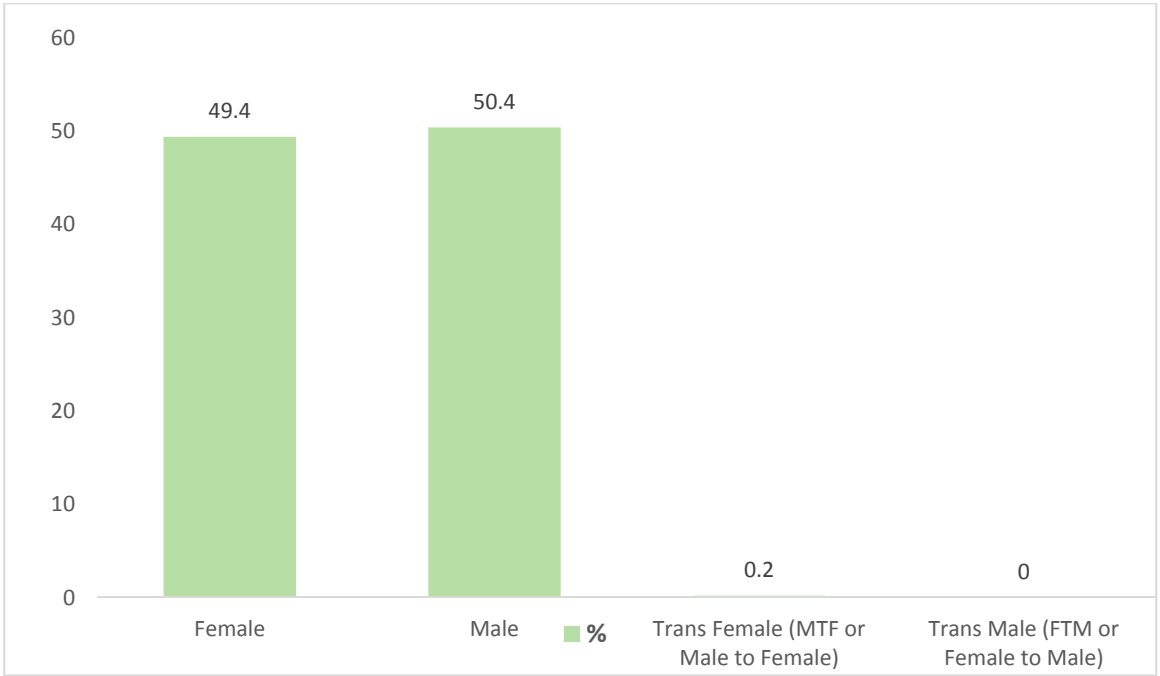


Figure 11. Race of JO enrollees

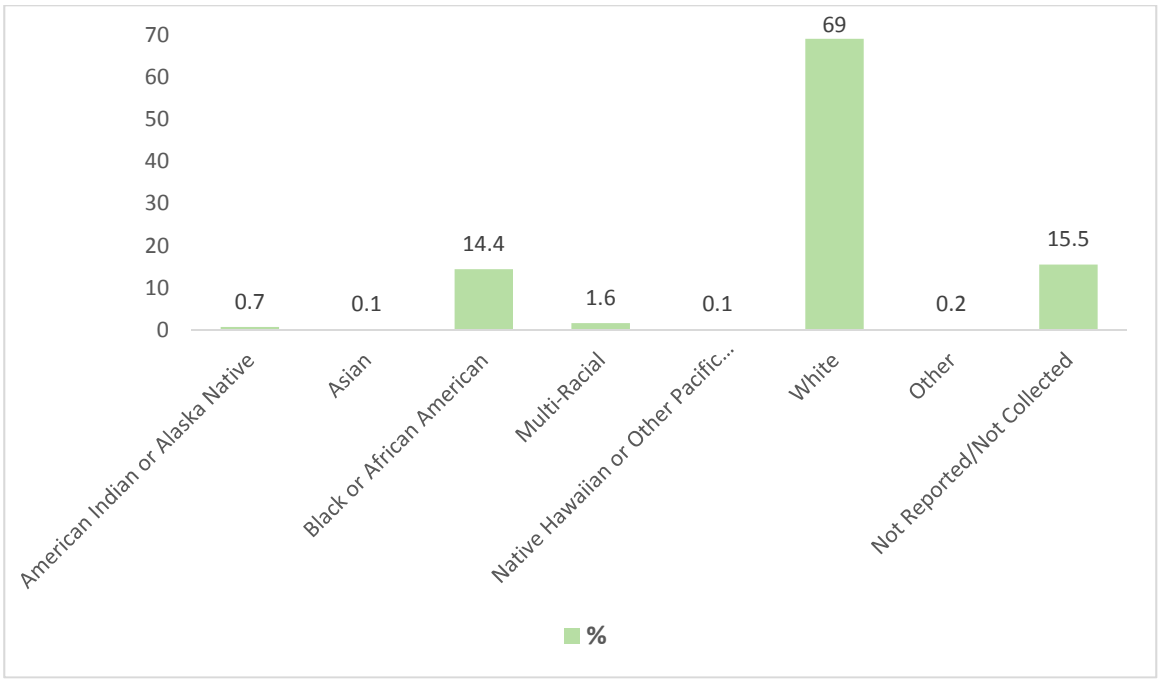


Figure 12. Ethnicity of JO enrollees

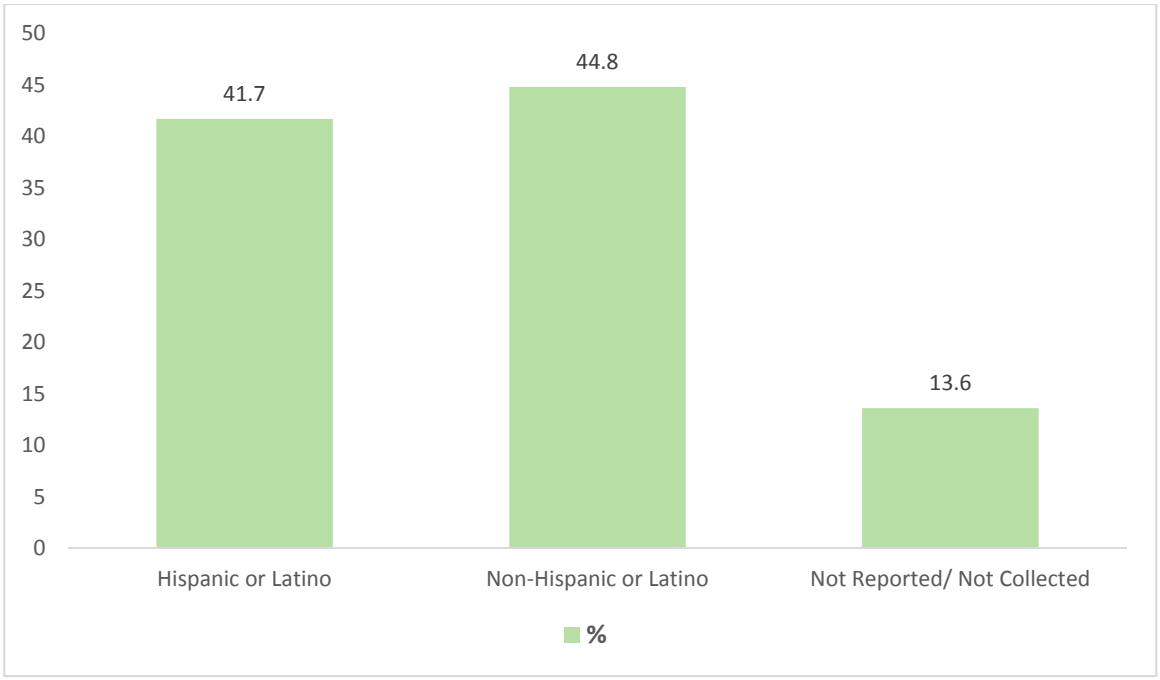
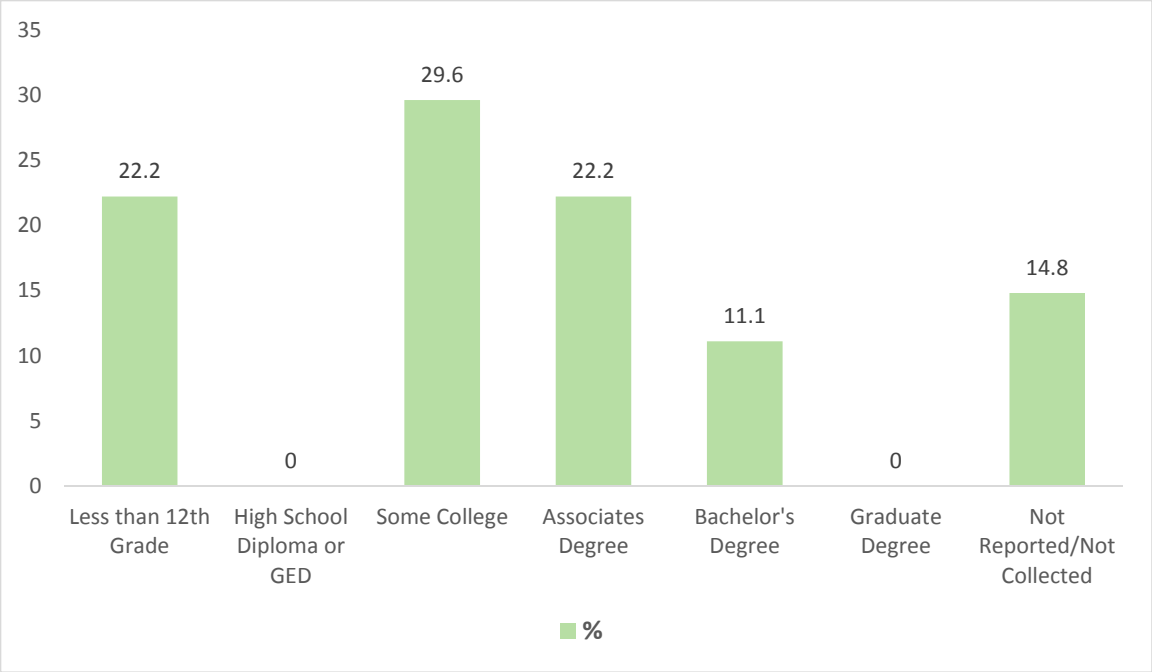


Figure 13. Education status of JO enrollees



History of homelessness

Most JO enrollees reported having had at least one homeless episode in the past three years, with one quarter reporting four or more episodes. About half reported having spent more than one year experiencing homelessness out of the past three years, although one-fifth reported only one month where the month of enrollment was the first month (See Tables 7 - 8 and Figures 14 - 15).

Figure 14. Number of homeless episodes in the past three years of JO enrollees

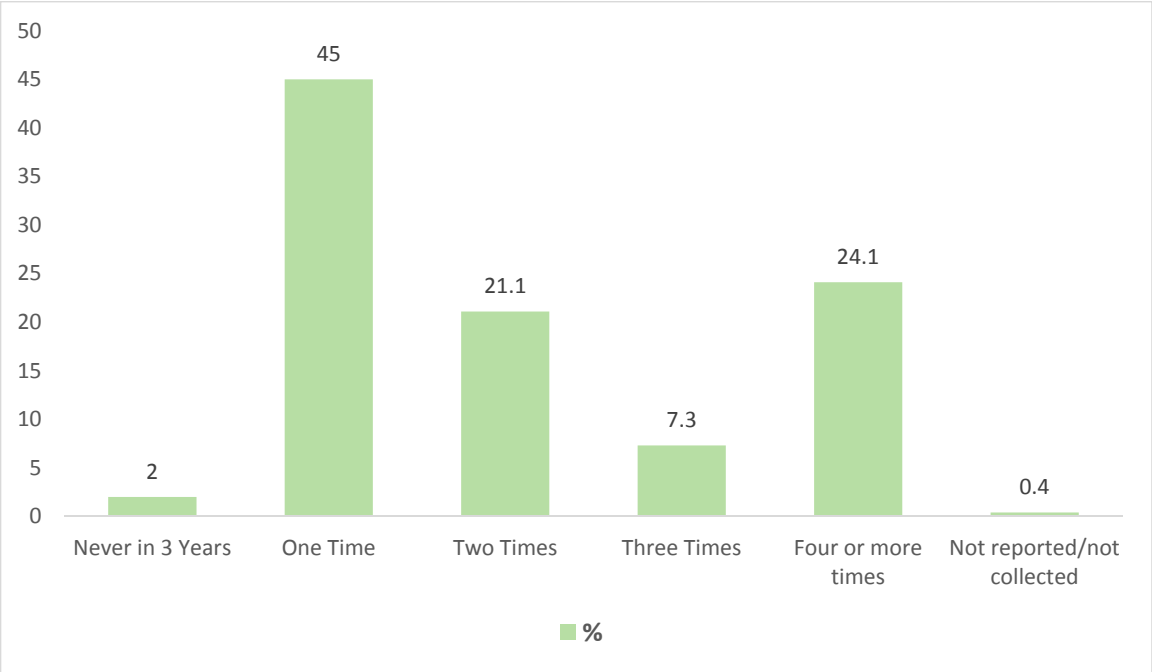


Table 7. Number of homeless episodes in the past three years of JO enrollees

Number of episodes	N (%)
Never in 3 years	10 (2.0)
One Time	222 (45.0)
Two Times	104 (21.1)
Three Times	36 (7.3)
Four or more times	119 (24.1)
Not reported / Not collected	2 (0.4)
Missing	843

Figure 15. Number of months experiencing homelessness in the past three years of JO enrollees

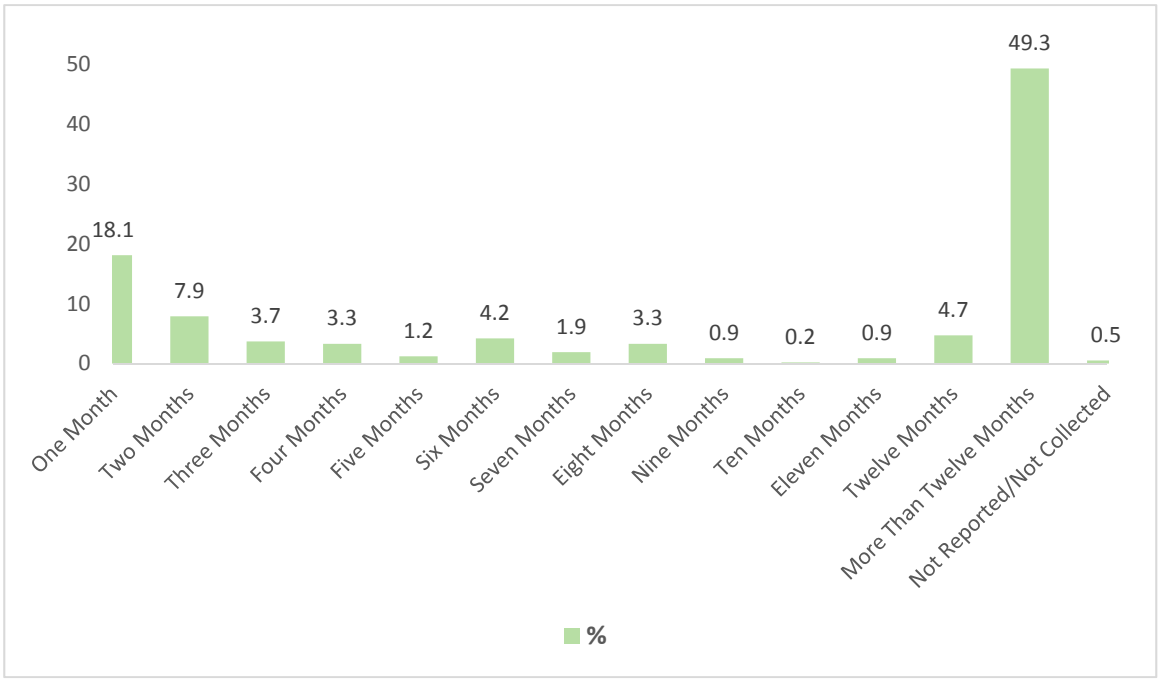


Table 8. Number of months experiencing homelessness in the past three years of JO enrollees

Number of months	N (%)
One Month (this time is the first month)	78 (18.1)
Two months	34 (7.9)
Three months	16 (3.7)
Four months	14 (3.3)
Five months	5 (1.2)
Six months	18 (4.2)
Seven months	8 (1.9)
Eight months	14 (3.3)
Nine months	4 (0.9)
Ten months	1 (0.2)
Eleven months	4 (0.9)
Twelve months	20 (4.7)
More than twelve months	212 (49.3)
Not reported / Not collected	2 (0.5)
Missing	906

Average length of enrollment (length of stay)

Average length of enrollment could only be analyzed for those members who had already exited the program at the time of data collection and not for those with active enrollment. Valid length of stay ranged from 0 to 867 days (n=1,203). Those with a length of stay of zero days (n=455) were excluded from analysis. The average length of stay in the JO program is approximately 62 days, or about two months (M(SD) = 61.6 (20.0); n=748). This average length of stay is heavily influenced by a large proportion of individuals who were enrolled in the program 30 days or less (n=452).

Services

Members enrolled in the JO program received services provided by Haven for Hope before, during, and after enrollment in the program (varies between individuals). The service data timeframe for each individual extends from point of intake / enrollment at Haven for Hope through either 1) the day the data was extracted or 2) the date of graduation (if already graduated) plus any future entry and exit dates.

For this analysis, only services received during the period of program enrollment and that are most closely tied to program purpose and goals are presented. Of these, the most frequently provided direct services included peer support, in-jail outreach, supportive services, case/care management, and enrichment activities (Table 9).

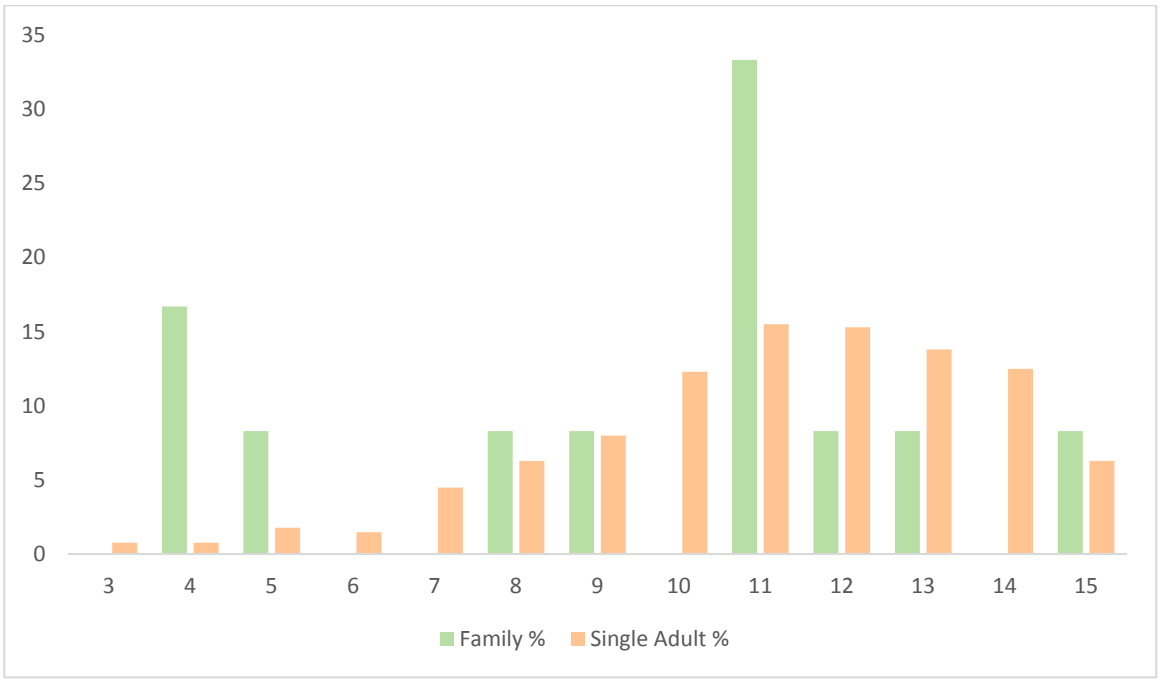
Table 9. Most frequent direct services provided during JO enrollment period

Type of service	Number of services provided to all enrollees
Peer Support Contact	8,532
Jail Outreach	4,186
Supportive Services	1,198
Case / Care Management	737
Enrichment Activities	574

VISPDAT

Preliminary analyses were conducted for the VI-SPDAT total score. Only scores belonging to the VI-SPDAT assessment conducted at first enrollment into the JO program are presented. Scores from other VI-SPDAT assessments conducted for other enrollments are not presented. The average total score for those completing the version for families fell in the high acuity range (M (SD) = 9.5 (3.6); n = 12; min = 4; max = 15). Most individuals for whom VI-SPDAT enrollment scores are available completed the version for single adults; the average score for this group also fell into the high acuity range (M (SD) = 10.2 (2.6); n = 400; min = 2; max = 15). Distribution (% of people) across total score by assessment type are presented in Figure 16.

Figure 16. Distribution of VI-SPDAT total scores by assessment type



Staff survey

Demographics

A total of 64 staff members and interns (of 276 total invited) across 17 departments within Haven for Hope responded to the survey, a response rate of 23.2%. Respondents represented a majority (77.3%) of Haven for Hope's 22 different departmental groups. See Table 10 for respondents by department of employment.

Table 10. Respondents by department

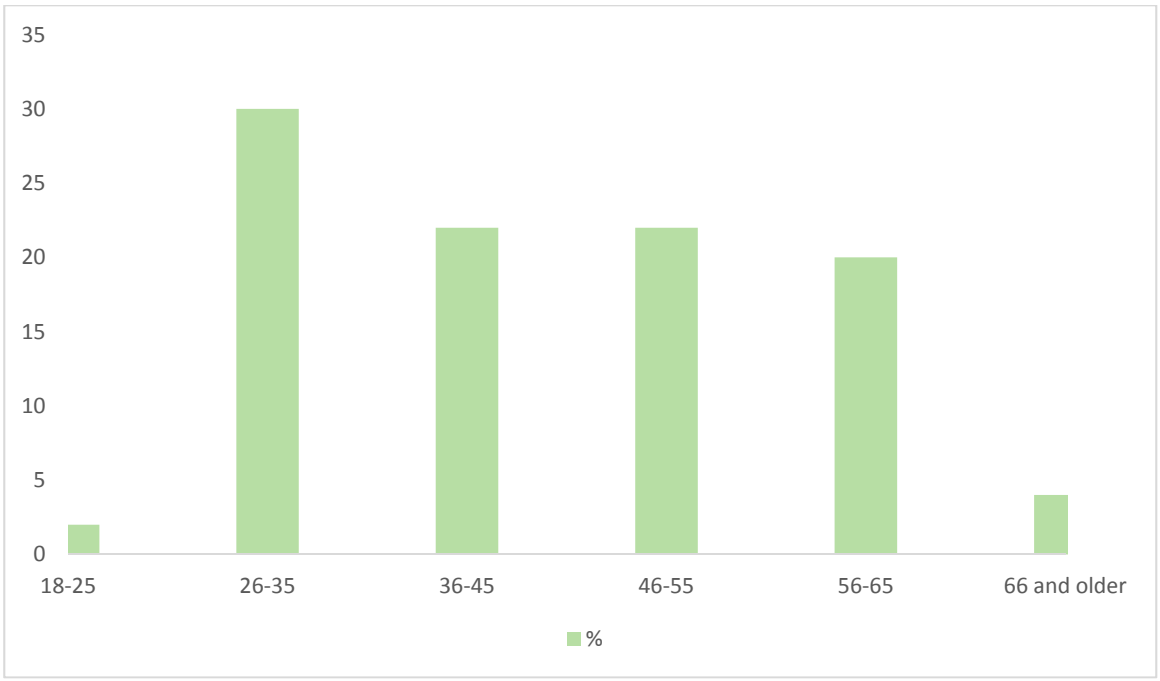
Department	N	%
Campus Services	12	18.5
CEO	12	18.5
Clinical Services	5	7.7
Coordinated Enrichment	3	4.6
Courtyard	5	7.7
Development	2	3.1
Employment Readiness	2	3.1
External Relations	1	1.5
Facilities	2	3.1
Fiscal	2	3.1
Housing Services	8	12.3
Intake	6	9.2
Legal	1	1.5
Life Safety	5	7.7
Partner Relations	1	4.6
Social Work Interns	3	4.6
Spiritual Services	3	4.6
Veterans Program	3	4.6

The average length of service (or duration of employment) at Haven for Hope for respondents was 43 months (*SD* = 27.9; range = 4 - 101), slightly longer than the average length of service of 37 months for all Haven staff at the time of the survey. Staff classified as 'peers' had a shorter length of service on average (31 months, n=10) than non-peer staff (45 months, n=52). Respondents represented ages ranging from 18 to over 66 years of age (Figure 17), and a majority reported *Female* gender (68%). About one-third (30%) of respondents reported *Hispanic/Latino* ethnicity, and most reported *White* as their race (68%). Nearly all (98%) of respondents spoke English fluently, and approximately 18% reported being fluent Spanish-speakers either as their primary or secondary language. A majority of respondents were college-educated (90%). See Table 11 for all demographics.

Table 11. Demographics of staff respondents

		N	%
Gender	Male	16	32
	Female	34	68
	Transgender / non-binary	0	0
Age	18 – 25	1	2
	26 – 35	15	30
	36 – 45	11	22
	46 – 55	11	22
	56 – 65	10	20
	66 and older	2	4
Hispanic or Latino origin?	Yes	15	30
	No	35	70
Race	American Indian / Alaska Native	5	7.7
	Asian	0	0
	Black or African American	6	9.2
	Native Hawaiian or other Pacific Islander	0	0
	White	34	52.3
	Other	5	7.7
Primary language	English	47	94
	Spanish	3	4.6
Secondary language fluency?	No	41	82
	Yes (*English* – 2, *Spanish* – 6, *German* – 1)	9	18
Education	High school diploma or GED	5	10.0
	Some College	14	28.0
	Associates Degree	4	8.0
	Bachelor's Degree	9	18.0
	Graduate Degree	18	36.0

Figure 17. Age ranges of staff respondents



Lived experience

A large majority (78%) of staff respondents reported some type of lived experience (trauma, mental health, substance use, incarceration, and/or homelessness), with 66% reporting having more than one type and 18% having all five types of lived experience presented by the survey. The most common type of lived experience was that of trauma, with 70% of respondents reporting experience with trauma. See Table 12 and Figure 18 for responses by each category of lived experience. Proportionally fewer staff in *Administration* type roles reported having any type of lived experience (57.1%) than staff in *Direct Service* roles (81.4%).

Figure 18. Percentage of Respondents with Lived Experience by Type

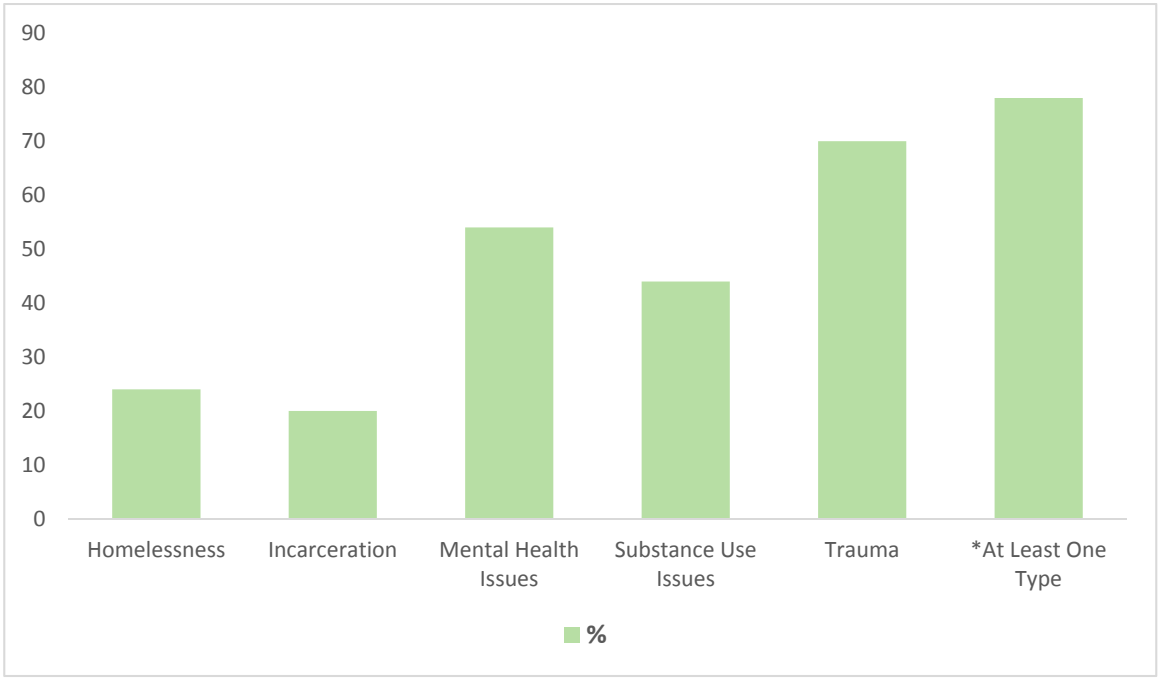


Table 12. Lived Experience of Respondents by Type

Type of Lived Experience	N	%
Homelessness	12	24
Incarceration	10	20
Mental Health Issues	27	54
Substance Use Issues	22	44
Trauma	35	70
*At least one type	39	78

At the time of the survey, 21 staff (7.6% of all staff and interns) at Haven for Hope were classified as 'peers' working in a peer support role; about half of those (n=10) responded to the survey. Among the seven peer staff responding to this item, all reported more than one type of lived experience and over half (57.1%) reported all five types of lived experience. All (100%) reported lived experience with mental health issues, 85.7% with substance use issues, 71.4% with trauma, and 57.1% with both homelessness and incarceration. Most (85.7%) reported experience with both mental health and substance use.

Beliefs about recovery

The average score on the RKI mental health scale (RKI-MH) (*n*=64, 3.70 (.59)) was approximately equal to the average score on the RKI substance use scale (RKI-SU) (*n*=48, 3.70 (.59)). The two scales were strongly correlated ($r = .87$, $p < .00$, two-tailed) and both had high internal consistency, indicating that the items on each scale were measuring the same construct (RKI-MH $\alpha = .90$ and RKI-SU $\alpha = .90$).

Stigma

The average score on the MICA-TR was high (*n*=55, 81.67 (7.64)), and the scale had adequate internal consistency, indicating that the items on the scale were generally measuring the same construct ($\alpha = .70$).

Average Scores for the RKI-MH, RKI-SU, and the MICA-TR are presented by department in Table 13. Only departments in which a survey respondent worked at the time of the survey are included. The department with the highest average score across all three instruments was *Clinical Services.* The department with the lowest average score across all three instruments was *Life Safety.* Note that the number of staff respondents varied by department.

Table 13. Average Scores for recovery knowledge and stigma by department: Number, Mean, Standard Deviation

Department	RKI MH	RKI SU	MICA TR
	Mean (SD)	Mean (SD)	Mean (SD)
Campus Services	3.84 (0.42)	3.89 (0.35)	84.90 (4.56)
CEO Office	3.25 (0.00)	-	80.00 (0.00)
Clinical Services	**4.41 (0.81)**	**4.27 (1.02)**	**87.80 (4.87)**
Coordinated Enrichment	3.35 (0.31)	3.30 (0.31)	76.67 (5.03)
Courtyard	3.30 (0.43)	3.31 (0.32)	83.33 (8.08)
Development	3.33 (0.67)	3.55 (0.57)	82.00 (4.24)
Employment Readiness	3.20 (0.07)	3.35 (0.21)	70.50 (0.71)
External Relations	3.90 (0.00)	4.10 (0.00)	86.00 (0.00)
Facilities	3.48 (0.67)	3.95 (0.00)	75.40 (20.65)
Fiscal	3.13 (0.32)	2.90 (0.00)	72.00 (0.00)
Housing Services	4.26 (0.56)	3.92 (0.78)	85.38 (7.31)
Intake	3.68 (0.65)	3.74 (0.40)	84.40 (5.86)
Legal	3.65 (0.00)	3.45 (0.00)	80.00 (0.00)
Life Safety	**3.02 (0.14)**	**2.95 (0.05)**	**68.75 (4.65)**
Partner Relations	-	-	-
Social Work Interns	3.57 (0.16)	3.53 (0.23)	82.67 (4.51)
Spiritual Services	3.92 (0.38)	4.13 (0.18)	82.00 (2.83)
Veterans Program	3.78 (0.29)	3.63 (0.29)	81.00 (1.73)

Note: A lower score on the RKI (out of 5 total points) indicates more limited recovery knowledge. A lower score (out of 96 total scale points) on the MICA-TR indicates a more negative attitude / greater stigma toward mental illness.

At the time of the survey, most Haven for Hope staff were classified as 'Direct Service' (n=219; 78.8%) with 21.2% classified as 'Administration.' Respondents in Administration roles had lower scores on the RKI-MH, RKI-SU, and MICA-TR than those in Direct Service roles (Table 14). Note that there are far fewer staff respondents working in Administration roles than Direct Service roles.

Table 14. Average Scores for recovery knowledge and stigma by provider type: Mean (Std. Deviation), Number

Provider Type	RKI MH	RKI SU	MICA TR
	Mean (SD)	Mean (SD)	Mean (SD)
	Number	Number	Number
Administration	3.47 (.47)	3.58 (.49)	79.10 (9.12)
	N=9	N=6	N=8
Direct Service	3.81 (.59)	3.73 (.60)	82.11 (7.37)
	N=55	N=42	N=47

Note: A lower score on the RKI (out of 5 total points) indicates more limited recovery knowledge. A lower score (out of 96 total scale points) on the MICA-TR indicates a more negative attitude / greater stigma toward mental illness.

While staff with lived experience demonstrated lower stigma scores overall when compared with staff with no lived experience, they also demonstrated marginally lower scores of recovery-oriented beliefs / knowledge (Table 15). Note, there are far fewer staff that report no lived experience than those staff with lived experience.

Table 15. Average Scores for recovery knowledge and stigma by lived experience: Mean (Standard Deviation), Number

Lived Experience (Yes/No)	RKI MH Mean (SD) Number	RKI SU Mean (SD) Number	MICA TR Mean (SD) Number
No	3.83 (0.72) N=11	3.74 (0.78) N=10	82.00 (6.69) N=11
Yes	3.74 (0.55) N=39	3.71 (0.53) N=37	82.46 (6.96) N=39

Note: A lower score on the RKI (out of 5 total points) indicates more limited recovery knowledge. A lower score (out of 96 total scale points) on the MICA-TR indicates a more negative attitude / greater stigma toward mental illness.

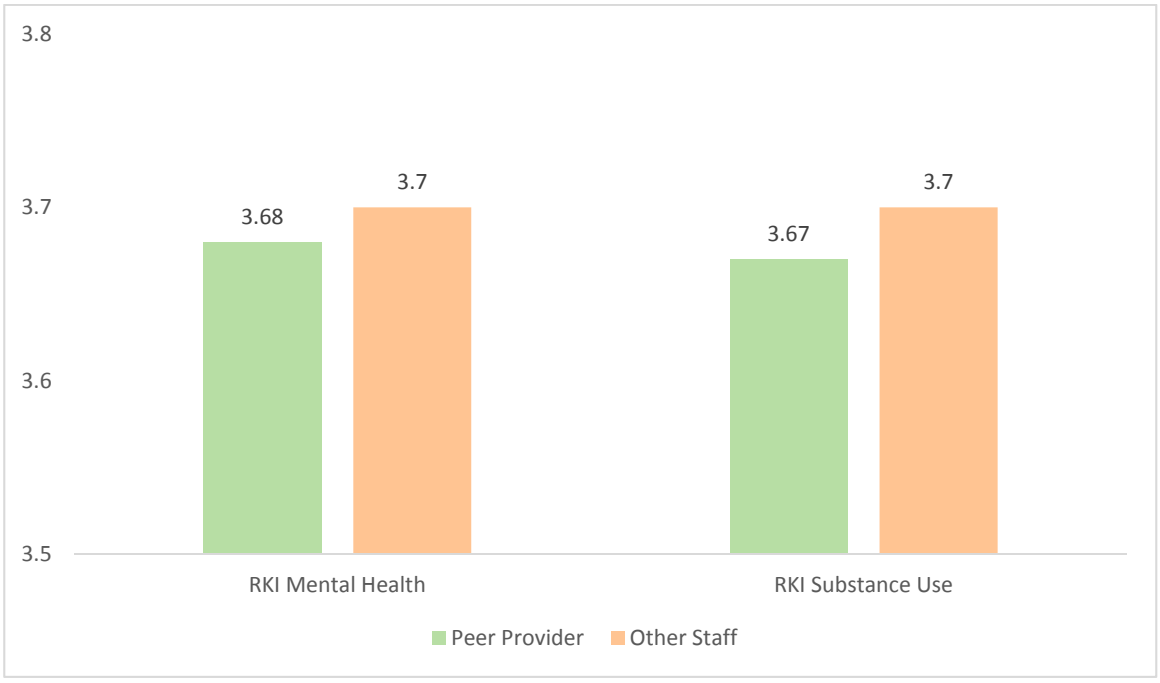
While peer staff demonstrated slightly less stigma than non-peer providers, they had marginally lower scores for recovery knowledge in the domains of both mental health and substance use. See Table 16 for a description of recovery knowledge and stigma scores by provider role, and Figure 19 for recovery knowledge by provider role.

Table 16. Average Scores for recovery knowledge and stigma by peer provider role: Mean (Std. Deviation), Number

Peer Provider (Yes/No)	RKI MH Mean (SD) Number	RKI SU Mean (SD) Number	MICA TR Mean (SD) Number
No	3.70 (0.68) N=54	3.70 (0.60) N=41	81.31 (7.88) N=48
Yes	3.68 (0.48) N=10	3.67 (0.53) N=7	84.14 (5.46) N=7

Note: A lower score on the RKI (out of 5 total points) indicates more limited recovery knowledge. A lower score (out of 96 total scale points) on the MICA-TR indicates a more negative attitude / greater stigma toward mental illness.

Figure 19. Recovery knowledge by provider role



Note: The RKI scale ranges from 1 to 5, with a higher score indicating greater recovery knowledge / recovery-oriented beliefs.

Discussion

Recovery outcomes

PSH enrollees tended to be older and more male with lower acuity than JO enrollees. As expected, length of stay is significantly longer in the PSH program than in JO. The most frequently received services in the PSH program are predominately peer and case management services. The unique characteristics of PSH enrollees may influence engagement with peer or other types of providers. While results are preliminary, further analysis will clarify the pattern of service engagement, acuity over time, length of stay, recidivism of enrollees in PSH, and what relationship these outcomes may have with peer support services.

JO enrollees, about half men and half women, are younger than PSH and 60% are college educated. Acuity is higher for JO enrollees than for PSH. They experienced overall fewer homeless episodes in the past three years, having spent fewer months experiencing homelessness, although these differences appear to be small. Average length of stay for JO enrollees is much briefer than for PSH, and while direct services most frequently received do include peer and case management services, the shorter length of stay probably indicates that long term relationships with peers and case managers do not have the same influence that they do for people in PSH. While results are preliminary, further analysis will clarify the pattern of service engagement, acuity, length of stay, recidivism of enrollees in JO, and what relationship these outcomes may have with peer support services.

Stigma and recovery knowledge

In the given sample of staff respondents to the survey, while there are some marginal differences, recovery knowledge and stigma does not significantly differ between peer providers and other types of providers, or between people in direct service roles versus administrative service roles, or between people with or without reported lived experience. However, more pronounced differences emerge when looking across departments at Haven for Hope, providing insight into which departments to target with specific training, supervisor support, and policy. While results are preliminary, further analysis will clarify whether staff working in the target programs specifically differ from other staff in terms of stigma and recovery knowledge as well as how any differences may influence recovery outcomes.

Trauma in the workplace

While results indicate that there may be some slight differences in the attitudes toward recovery and recovery knowledge of staff at Haven for Hope, varying by department, direct service versus administrative job type, peer role, and lived experience, organizational and structural factors have a stronger impact on recovery through the moderating influence they have on the relationship between individual-level staff characteristics and member outcomes.

Results indicated that 70% of staff reported lived experience with trauma, which is in line with trauma prevalence estimates in the general population (about 70%; Foreman, 2018). Prevalence in populations receiving outpatient mental health services (i.e., the population being served by staff) is estimated to be even higher, ranging from 82% to 94% (Williams, Helm, & Clemens, 2012). This combination of staff with high rates of trauma and people

receiving services with high rates of trauma has the potential to result in very high rates of ST and burnout for staff, unless mitigated by organizational practice and policy.

Conclusions and Recommendations

Limitations

One limitation that hinders the ability to make associations between frequency and type of peer-provided service and member recovery outcomes is that Haven for Hope does not classify peer positions consistently at an organizational level. The variety of programs in which peers work and titles, combined with the lack of a specific peer provider type at the organizational level, obscures which employees are working in 'peer' roles and therefore makes it difficult to compare outcomes between groups by type of provider or to identify correlations with type of provider.

Another limitation hindering this ability to identify relationships between peer services and outcomes is that staff who are working in peer roles at Haven for Hope are often providing a mixture of case management or other services along with peer services. This role straddling not only blurs the delineation of what is a peer support service and what is clinical, but it also inevitably dilutes the power of the peer relationship, mutuality, and the effectiveness of peer services. So, not only is it more difficult to measure impact, but the impact of peer support is also weakened when peers wear many hats.

Finally, a small sample size for the staff survey also limits the ability to detect differences between groups which may exist but cannot be identified with limited numbers.

Target areas for training, supervisor support, and policy

Training for all staff

While Haven for Hope's broad standard training repertoire for new employees seems to adequately address introductory recovery-oriented service topics (including Trauma Informed Care), formalizing training on Secondary Trauma (ST) as an occupational health issue would address stigma about mental health issues amongst staff, increase productivity, and improve employee retention. Improvements in these areas are likely to strengthen the recovery outcomes of members. Implementation research indicates that training on ST should focus on normalizing negative emotions in response to stressful work events, recognizing the signs of ST and compassion fatigue, and educating about effective preventative strategies at both the individual and organizational levels. Haven for Hope may consider including a training of this type in their core new hire trainings as research suggests that training of all staff – from front-desk to direct care staff to leadership – should be implemented to help prevent employee ST and burnout. However, training by itself will not be sufficient to prevent ST. While training will assist with further shifting the Haven for Hope culture to one that that normalizes negative emotions in response to traumatic stress at work (and the needs that follow), supportive action such as routine outreach and caseload balancing should also be considered at the organizational and departmental levels:

> *I don't expect my boss to be like, "Here's $2,000.00. Here, take off 20 people [from your caseload]." No, that's not what we expect, but we walk away sometimes feeling that it's us when we know it's not us, but it's like, "Wait, did you just push that back on me and I'm just trying to feel safe?" The environment doesn't feel as safe.*
>
> – case manager in Haven for Hope Healthy Community Collaborative focus group (TIEMH, 2016)

Routine outreach following critical incidents

Supplemental to training, Haven for Hope should consider formalizing support for on-the-job traumatic events and chronic exposure to ST. Peer staff in the target programs do indicate that their supervisors are highly supportive of their needs to process a traumatic experience or ST at work, however research on preventing ST and burnout suggests that such practices should be standardized throughout an organization and all departments, and that they should be implemented automatically as a standard practice. In other words, any time an employee has this type of experience, the supervisor would provide certain type of critical incident support, eliminating the need for the employee to self-select for support, and thereby minimizing the possibility that employee reactions to critical incidents would be stigmatized. Previous focus groups conducted with case management staff at Haven for Hope reveal that staff do experience stigma from co-workers as a reaction to opting to implement self-care strategies for themselves:

> *I had two deaths in one month. That was the end of July. I took just the afternoon off but, when I came back, I felt that tension. You don't need to say it, I feel it. I'm like, "Are you kidding me? I just lost another member and I took just a few hours off because I felt myself not being myself, being ugly." So I need to go home and take care of what I needed to take care of but, when I came back, there was tension.*
>
> – case manager in Haven for Hope Healthy Community Collaborative focus group (TIEMH, 2016)

Caseload balancing and policies that support self-care

Research also suggests that hours worked should be limited to avoid excessive work hours, caseloads should limit the number of complex traumas, and self-care policies should be officially sanctioned. Peers in the target programs do report that their supervisors are attuned to this need, for example, they remind employees to turn their phones off when they leave and allow staff some flexibility in scheduling job duties on the day following a critical incident. However, that may not be the case across the organization, as previous focus groups with peer staff at Haven for Hope have revealed issues with organizational support for claiming time and resources needed to recover from critical incidents:

> 1. *[It] can put me in a bad place personally going in that apartment and checking if somebody's dead or alive. […] Just the thought of walking in there not knowing what you're going to see, like every corner you turn, every door you open, you're like, "Ah, thank God. There's nobody back there." But it definitely puts me in a bad place. […] Are you going to lose your job because something triggered and you're depressed or you just got to get yourself out of this slump?*
>
> 2. *Our supervisor is always open for you to talk to him, but […] I don't really know what the solution is, like if they actually have a counselor for employees here that you could go see, something like that. […] I think that's, not that they don't try, but I think that that's something that's a gap that maybe they could fill.*
>
> 3. *I know this may seem petty, I just I don't want to have to use my PTO for grieving over someone that we work with.*
>
> – peer providers in Haven for Hope Healthy Community Collaborative focus group (TIEMH, 2016)

Staff ability to engage with members can be immediately and positively affected by training, supervisor support, and policies aimed at reducing ST among staff. Haven for Hope should consider these and other evidence-based practices for reducing ST and improving retention toward the goal of improved recovery outcomes.

References

Bedregal, L., O'Connell, M., & Davidson, L. (2006). The recovery knowledge inventory: Assessment of mental health staff knowledge and attitudes about recovery. Psychiatric Rehabilitation Journal, 30(2), 96–103.

Bellamy, C., Schmutte, T., Davidson, L. (2017). An update on the growing evidence base for peer support. Mental Health and Social Inclusion, 21(3), 161-167.

Bober, T., Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? Brief Treatment and Crisis Intervention, 6(1), 1-9.

Cabassa, L. J., Camacho, D., Vélez-Grau, C. M., & Stefancic, A. (2016). Peer-based health interventions for people with serious mental illness: A systematic literature review. Journal of Psychiatric Research, 84, 80-89.

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, 65(4), 429-441. doi:10.1176/appi.ps.201300244

Chinman, M., Oberman, R. S., Hanusa, B. H., Cohen, A. N., Salyers, M. P., Twamley, E. W., & Young, A. S. (2015). A cluster randomized trial of adding peer specialists to intensive case management teams in the Veterans Health Administration. The Journal of Behavioral Health Services & Research, 42(1), 109-121. doi:10.1007/s11414-013-9343-1

Corrigan, P. W., Kraus, D. J., Pickett, S. A., Schmidt, A., Stellon, E., Hantke, E., & Lara, J. L. (2017). Using peer navigators to address the integrated health care needs of homeless African Americans with serious mental illness. Psychiatric Services, 68(3), 264–270.

Davidson, L., Bellamy, C., Chinman, M., Farkas, M., Ostrow, L., Cook, A.,…Salzer, M. (2018). Revisiting the rationale and evidence for peer support. Psychiatric Times, 35(6), 1-3.

Felton, C. J., Stastny, P., Shern, D. L., Blanch, A., Donahue, S. A., Knight, E., & Brown, C. (1995). Consumers as peer specialists on intensive case management teams: impact on client outcomes. Psychiatric Services, 46(10), 1037–1044. doi:10.1176/ ps.46.10.1037.

Foreman, T. (2018). Wellness, exposure to trauma, and vicarious traumatization: A pilot study. Journal of Mental Health Counseling, 40(2), 142-155.

Fuhr, D. C., Salisbury, T. T., De Silva, M. J., Atif, N., Ginneken, N. V., Rahman, A., & Patel, V.(2014). Effectiveness of Peer Delivered Interventions for Severe Mental Illness and Depression on Clinical and Psychosocial Outcomes: A Systematic Review and Meta-Analysis. Social Psychiatry and Psychiatric Epidemiology, 49(11), 1691–1702.

Gidugu, V, Rogers, E.S., Harrington, S., Maru, M., Johnson, G., Cohee, J., Hinkel, J. (2015). Individual peer support: a qualitative study of mechanisms of its effectiveness. Community Mental Health Journal, 51(4), 445–452. doi: 10.1007/s10597-014-9801-0.

Haven for Hope, 2018. Homeless Management Information System. Retrieved from https://www.havenforhope.org/HMIS.

Jonikas, J. A., Grey, D. D., Copeland, M. E., Razzano, L. A., Hamilton, M. M., Floyd, C. B., . . . Cook, J. A. (2013). Improving propensity for patient self-advocacy through wellness recovery action planning: Results of a randomized controlled trial. Community Mental Health Journal, 49(3), 260-269. doi:10.1007/s10597-011-9475-9

Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinics working with trauma survivors. Traumatology, 14(2), 32-44.

Mahlke, C.I., Priebe, S., Heumann, K., Daubmann, A., Wegscheider, K., & Bock, T. (2017). Effectiveness of one-to-one peer support for patients with severe mental illness – a randomized controlled trial. European Psychiatry, 42, 103-110.

Maltzman, S. (2011). An organizational self-care model: Practical suggestions for development and implementation. The Counseling Psychologist, 39(2), 303-319.

Mangrum, L., Spence, R., Nichols, M., & Peterson, C. (2017). Recovery support services project, fiscal year 2016: Final evaluation report. University of Texas at Austin: Addiction Research Institute.

New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America, final report (DHHS Publication No. SMA-03-3832). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Oh, H. & Rufener, C. (2017). Veteran Peer Support: What Are the Mechanisms? Psychiatric Services, 68(4), 424. doi: 10.1176/appi.ps.201600564.

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S., Ryan, R., & Berends, L. (2013). Consumer-providers of care for adult clients of statutory mental health services. Cochrane Database of Systematic Reviews, 3, CD004807. doi:10.1002/14651858.CD004807.pub2

Rogers, E., Maru, M., Johnson, G., Cohee, J., Hinkel, J., & Hashemi, L. (2016). A randomized trial of individual peer support for adults with psychiatric disabilities undergoing civil commitment. Psychiatric Rehabilitation Journal, 39(3), 248-255. doi:10.1037/prj0000208

Salzer, M., Rogers, J., Salandra, N., O'Callaghan, C., Fulton, F., Balletta, A., . . . Brusilovskiy, E. (2016). Effectiveness of peer-delivered center for independent living supports for individuals with psychiatric disabilities: A randomized, controlled trial. Psychiatric Rehabilitation Journal, 39(3), 239-247. doi:10.1037/prj0000220

Sansbury, B. S., Graves, K., Scott, W. (2015). Managing traumatic stress responses among clinicians: Individual and organizational tools for self-care. Trauma, 17(2), 114-122.

Scanlan, J. N., Hancock, N., & Honey, A. (2017). Evaluation of a peer-delivered, transitional and post-discharge support program following psychiatric hospitalization. BMC Psychiatry. 17(1), 307.

Substance Abuse and Mental Health Services Administration. (2015). Recovery and recovery support. Retrieved from https://www.samhsa.gov/recovery.

Substance Abuse and Mental Health Services Administration. (2014) Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Texas Institute for Excellence in Mental Health. (2018). Mental Illness Clinicians' Attitude Scale – TIEMH Revised. Adapted from Mental Illness: Clinicians' Attitudes Scale MICA-2 © 2010.Health Service and Population Research Department, Institute of Psychiatry, King's College London.

Warren, J., Morgan, M„ Morris, L. B., & Morris, T. M. (2010). Breathing words slowly: Creative writing and counselor self-care—the writing workout. Journal of Creativity in Mental Health, 5, 109-124.

Williams, A. M., Helm, H. M., & Clemens, E. V. (2012). The effect of childhood trauma, personal wellness, supervisory working alliance, and organizational factors on vicarious traumatization. Journal of Mental Health Counseling, 34(2), 133-153.