

Process and Qualitative Outcomes of Rider 73

Evaluation Executive Summary

Introduction

This report summarizes the results from focus groups and longitudinal one-on-one interviews with Certified Peer Specialists (hereafter referred to as peer specialists) funded through Rider 73, the *Mental Health Peer Support Re-Entry Pilot Project*. The larger evaluation was funded by the Hogg Foundation for Mental Health and conducted by Dr. Jennifer Reingle Gonzalez at the University of Texas School of Public Health in Dallas.

The Mental Health Peer Support Re-entry Pilot Project was conceptualized to leverage peer experiences to empower justice-involved persons to successfully transition from jail into communities. These formerly justice-involved individuals, peer specialists, facilitate participant engagement in community-based mental health programs and services. The overarching goal of the evaluation is to examine whether peer specialists are effective in their ability to decrease recidivism, promote community tenure, and encourage recovery of clients released from jail across each of the three project sites (Tarrant County, Harris County and the Rio Grande Valley). Peer specialists provide general mental health peer support services to facilitate successful transition from incarceration to community-based services.

To assess program effectiveness from the perspectives of peer specialists and other program staff, focus groups were conducted at each site between October and November, 2016 to qualitatively assess the impact of the peer specialist program on project outcomes (reduced re-arrest, decreased symptomology of mental health and substance use problems, and increased life domain functioning, including residential stability, employment, life skills and self-care). To gather more granular data about peers' daily experiences, each peer was interviewed individually during October/November and follow-up interviews were conducted 6-months later (March/April, 2017). Prominent themes that emerged from these sessions are described below.

Evaluation Findings

Program Processes

Peer specialists reported caseloads between 3 and 16 clients per peer. Caseloads varied greatly across each site. Peers suggested that clients recently re-entering the community require more hours each week than clients who have been in the community receiving services for several weeks. One peer suggested that she could handle 35-40 clients in the community at one point in time. Other peers suggested that caseloads of 12 to 15 would be more manageable to avoid compromising service provision.

Most clients were actively engaging in the program. At the 6-month interview (April / May 2017), less than ten clients were successfully discharged from the program. Peers reported that clients were typically discharged 8-9 months after they began working with their peer, as *“within the first two months, it is definitely a lot of handholding.”* At one site, only two clients were discharged between program implementation and April / May. Another peer reported that 8 or 9 of her clients were discharged during the same time frame; therefore, there is a high degree of variability in program progression according to site and/or peer. Overall, peers suggested that it would take far longer than 90 days for clients to become independent on their own; in fact, most peers identified that they would like to work with clients for a year or more (range of time from intake to independence was 4 months to one year).

Peers reported having the ability to sense when the time is right for a client to be discharged. For example, independent clients often begin taking the initiative to proactively care for themselves: *“...she had felt she had gotten everything she needed ... she wanted to be on her own”*, *“he started keeping all*

his appointments on his own ... [the client used] my services less and less, but he's still keeping me in the loop ... after a time, just slowly let them go", and, "[the client is] at a place where he's living on his own and doing well, basically has reentered. When he has a hiccup, he knows how to address them." Peers suggested that the amount of time needed in the program varied across clients, and there is no universal timeline or deadline by which clients would be ready for discharge.

All peers suggested that it was not immediately apparent to them whether a client would be successful in the program or not after the initial peer-client meeting. Some clients change over time," *[at the beginning of the program], everything was [client X's] way or no way, it's her time or not. And if she called you and wanted a ride you were supposed to take her. And, I mean, she was just all over the place. But [she] completely turned around and grow forward."* This can work both ways, "One [client] in particular I have worked with him for several months. He's stayed very compliant and then he just decided to go back to his old ways after maybe four, five months. Every scenario is different."

Value of Lived Experience

Peers were largely female and at one site, peers did not have a history of involvement with the criminal justice system. Peers believed that clients should be better matched with peers based upon their strengths and lived experiences: "... *[One of our peers] is experienced with the alcohol recovery and drug recovery world. For a lot of her [clients], she's been amazing in getting them into recovery centers and working with them and I think that's because she knows so much, and she's been able to help them maybe a better way than I could. So, yeah I think that lived experience might be a factor; which is good I think because then we're matched up with people that were better able to help."* Similarly, "a lot of times when you have people that have lived certain lives, and you have [peers] that don't have the experience [the client] has...they're like, you just read a book that's how you learned that -- you don't even know what I'm talking about." Therefore, a peer's lived experience can help build rapport, credibility, and practical experience in helping address client needs.

Lived experience was perceived as a valuable skill that enabled peers' ability to do their job, and peers' experience permeated every core function of peer responsibilities. For example, one peer valued her lived experience as more valuable than her master's degree, "even with me, having a [master's] degree I still feel without my lived experience my degree would not give me the knowledge I have. Like, my lived experience just is way [more important than] my degree... I feel like you just benefit over anyone that doesn't have lived experience. Because you know me...I can read, I can read, I can study, I can take tests. And none of that has been anything to do with what I do. I've got to be able to work with people, [recognize] the manipulation or the mind games they play, or the self-determination-- that all came from lived experience. That does not come from reading a textbook and taking tests. And I think that's overlooked". Peers use their experiences to help clients manage their own struggles: "I was able to relate [to clients because of] my trauma I've gone through in life. Then I was able to teach them about their traumas. Like, this is something you need to recognize, and this is the root of where things go wrong. And I learned that type of thing [from my own experience]." Peers suggested that lived experience "... makes someone an amazing person because they have lived it overcame it and now they're giving back with it...it's just from seeing myself and my past life, being able to prioritize my needs and wants today and share it with them." Therefore, peers identified lived experiences as a necessary factor for success in the peer role.

Peer Morale

Several peers perceived the peer role to be largely undervalued in their work environment. For instance, "I do think that peer title holds us back in some areas. And I think someone needs to look how beneficial we are. And even as a peer, I still feel like I'm a caseworker or like a clinician... because we're doing progress notes, we're doing tons of paperwork. Plus, we're [compiling] resources, plus we're meeting

with the client... we do so much more than so many. And it's overlooked. I don't think people really look at... what [peers do]." Despite this limited recognition, peers feel that their position is highly rewarding: *"[being a peer is rewarding. It helps me. They help me as much as I help [clients], I think. Working in this kind of field is rewarding for me, because it helps me. I love what I do and ... because I'm getting into some of the things that some of my clients have been through. [Helping clients] touches me and it helps me... and I've told them that... I love this job. I love peer support."* Peers are largely happy in their position and enjoy their work: *"I feel I'm just as a human as someone who wakes up at the morning I wake up excited to come and help [clients] and I don't ever feel like my job is work."*

Program Outcomes.

The purpose of this pilot program was to reduce recidivism, symptomology of mental health and substance use problems, and increase life domain functioning. One of the greatest difficulties that peers identified when working with clients is documentation: *"The biggest barrier [is that] they need documents. They have to have the documents to get the documents and so to me that sounds so crazy. But, because they don't have the documents to get the documents that is a big barrier"*, and *"it is not easy to just go and get an ID or social security card or birth certificate when you have nothing to prove who you are. ... But we're already at the point where she's ready to submit all the documentation. She wasn't able to even file for disability benefit because [she didn't have any documentation], so she's been struggling."* Although not a goal of the Rider 73 project, document attainment is a primary barrier that consumes peer effort across all three sites. Clients require identification cards before treatment, housing, or employment barriers may be addressed.

Recidivism

Peers work indirectly to address recidivism, which they believe to be an outcome of unaddressed mental health symptoms, substance use, housing, or unemployment. Very few peers mentioned arrests during the interviews. A client at one site stated that her peer helped her stay out of jail by *"I have wanted to relapse ... and I will call [my peer] and I'll tell her, like, 'This is happening. I need help.' She'll just talk me down, like, think about all the things that you've accomplished now, think about your daughter and because a lot of people – when I tried doing it with my mom, she just got mad at me and started yelling at me... [My peer] was a little bit more understanding, and more helping, and knew how to handle the situation."* Hence, this client's peer leveraged lived experiences to help the client manage family conflict.

One peer suggested that one of her clients has intentionally sought out arrest: *"[The clients] don't have any place to go, [lack of housing is] a major problem. They get rearrested on purpose so they have a place to stay.... And that happens more often than we even know."* Other peers suggest that their role becomes more challenging the longer that clients have been in the community, as clients are drawn to friends who use drugs out of comfort.

Housing

Housing was identified as one of the most challenging services for peers to link with clients. Peers suggested that, *"everyone wants housing"*, and *"sometimes there is a waiting list. We've got some of them in group homes, but some still are in shelters"*, or *"I get them on [a waitlist], but it still takes about a year."* Another peer stated, *"The one major barrier [to client success] that I'm having is that I can't find [clients] a place to live. [Clients] are not chronically homeless enough because if they were incarcerated and they come out even though they were homeless before they don't count being incarcerated as being homeless. [Clients must have] no mattress, no nothing for a year before they will even be considered for any type of [chronically homeless] housing. Therefore, clients coming out of jail are not eligible to receive housing earmarked for chronically homeless adults. Peers also suggested that it is more difficult for them to obtain housing for adults with specific types of charges, most notably, sex offenses: "...for the ones who are lifetime sex offenders, it's very difficult [to find housing]."*

In many cases, peers report that housing resources are available but the quality of these facilities makes them less desirable for clients. One peer stated that resources are available, but they are low quality: *“We have a supported housing unit, their funds are maxed out as well. There are shelters in the area, but you know they need certain things, some of them are not a place where you would want to stay, some of them are trying, they’re okay. But you open up to other people, you have family, you have men, you have all kinds of people in these shelters. And for some maybe it’s okay, for others that’s not somewhere they want to go you know, and so it’s difficult so they not – that leads them to try to fend for themselves on the streets.”* One client was *“prostituting and doing everything she could... she used to go to shelter because she was like ‘it’s gross, have you ever been there? You don’t know what it’s like.’ You know, I rather just do what I have to get a hotel...”* Although group homes are often available, some clients *“don’t want to go in group homes... They just don’t want to live with other people. Most of them want to be by themselves but ... the main other reason they don’t want to go is because they don’t want to live with other people.”*

Peers’ lived experience helps them relate to client’s housing needs. According to one peer who was formerly homeless herself, *“I have one [client] that was prostituting and doing everything she could, you know she refused to go to the shelter because she was like it’s gross, have you ever been there? You don’t know what it’s like. She said, ‘I would rather just do what I have to do to get a hotel and finally we were able to use some funds to get her into an apartment and its amazing transformation. Being homeless is not easy and I was homeless for two years and doing everything you can think of just to have a place.”* The same peer articulated the impact that housing had on one of her clients: *“It wasn’t until after she got her housing... being independent, which is something she wanted to experience. She was super happy – let me tell you something, it was beautiful and she was just so happy.”*

Decreased symptomology of mental health and substance abuse problems

Peers consistently identified the importance of mental health and substance use treatment in client success. When clients are *“able to admit [they have relapsed] and come back and got treatment”*, they are successful. In some sites, *“I can get them connected to mental health clinic easily. But their appointment might not be for ... five months later, because they would need to see a psychiatrist”*. Other peers suggested that certain clinics were problematic: *“some [clinics] are very welcoming and want to work with you, others ... they’re just not that good they don’t build a good rapport with you they’re -- if you come with a feeling of -- like they consider you to be left dead.”* Long wait times and poor quality clinical services were identified as a barrier at only one site.

Peers regularly use their lived experiences to prevent client relapse. As stated by one peer, *“One client was contemplating suicide because of his audio hallucinations and I shared my experience of having those same symptoms and being incarcerated and what I did to cope with them. And he cried because sometimes you feel like, man, am I alone in this, am I the only one that hears it, am I the only suffering from this?”* Another peer stated, *“[Clients] don’t want to stop using the drug. But they do want to get their life together, all I can do is tell them about my story ... if they continue on this path and it’s only going to lead you back to jail or even death.”* Peers believed that their lived experience was their most valuable tool in working with clients suffering from substance use and / or mental health symptomology.

Increased life domain functioning (residential stability, employment, life skills and self-care)

Employment

“[Clients] are still needing to live, they are still needing to support for themselves and trying to get a job or trying to manage not having the job or any finances going on the bare minimum of welfare. So yeah,

finance is number one...” One peer suggested that employment was an important factor for two of her clients. One client got a job, which her peer connected to the client’s relapse: “*we started talking about...relapse, but then when she started going over, what can we do in these moments when we’re thinking about using and you know she was working at a place that was not good. It was some place that was going to expose her to drugs. So I was like come on we got -- your environment where you’re working, is it a good choice if you are exposed to it?*” Another client had attained gainful employment and this helped him get back on his feet and become independent. A peer at another site suggested that motivating clients to work is a challenge, because “*some [clients] want a check though they don’t want a job.*” Peers are commonly working to address employment and income needs of their clients; however, peers struggle to ensure that clients’ employment is gainful and will not expose them to risk factors for relapse.

Transportation

Few clients have access to their own transportation, and many clients use peers for transportation especially during the first three months after release. One peer was particularly creative in addressing a client’s transportation needs: “*[The client] didn’t have transportation, and so he got a bike. I took him right after Christmas; he gets his check, his [social security]. He got him a bike. It’s a bike, but he’s doing really well.*” Most peers teach clients how to use buses for transportation, but in some urban locations, bicycles may be less expensive and more efficient over time.

Conclusion

Findings from the qualitative evaluation of Rider 73 suggest that peers are continually leveraging their lived experiences to address clients’ mental health and substance use, housing, and employment needs. A number of structural barriers, such as limited access to housing and long wait lists for clinical care, prevent peers from addressing client needs. Peer time is routinely consumed with obtaining documentation for clients, as identification is needed before any treatment or healthcare services may be used, or housing or employment can be sought. Despite these challenges, peer morale remains high and outlook positive.

Results from this evaluation suggest a number of barriers limiting program dissemination and success. First, the number of clients served by this program is limited by strict eligibility criteria, which varies substantially across sites (e.g., clients must have never used clinical services in the past to be eligible for this program). Additionally, peers can handle substantially larger caseloads than they currently have. A more formal graduation ceremony might be implemented to celebrate client’s success and serve as a model for others currently progressing through the program. Finally, peers might be provided more flexible work hours to meet clients outside of normal business hours.