Aggregate Enhanced Day Treatment Report, 2009

October 2009

Consumer Quality Initiatives, Inc.

CQI's mission is to "give consumers a greater voice and an integral role in evaluating the effectiveness of their [our] treatment" through "fair, honest and balanced" reports on consumer perception of quality and satisfaction. CQI provides a forum for that voice through confidential interviews with Mass Health clients. In addition to providing valuable information to the Partnership and providers, CQI hopes to initiate changes that will improve the system for all; consumers and providers alike. Through these interviews and small group discussions among consumers, providers and health care authorities, CQI is beginning to bridge information gaps to establish a common understanding of quality and mental health.

CQI interviewers are consumers or family members of consumers of mental health services who have received extensive training in interviewing with this population. Because of their personal experiences with mental illnesses, these interviewers are able to build a rapport with respondents that appears to help the individuals who are interviewed speak openly and honestly about their treatment experiences.

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1 EXECUTIVE SUMMARY

Sample Demographics

Two hundred and ninety clients **(N=270)** at twelve enhanced day treatment programs were interviewed between January and April 2009.

Mean/Median **length of time attending program**(at time of interview)	**27/9 months**
Mean/Median **age of respondents**	**43/45 years**
Percent **male/female**	**38%/ 63%**
Percent of clients from programs with peer specialist on staff/peer led groups[1]	**65%/35%**
Percent with GED or higher	**82%**

Summary of Findings

Key Areas of Strength

- **Treatment Planning** – Over 90% of respondents agreed that staff follow their choices in treatment planning. In addition, 90% of respondents agreed that they were able to choose from a variety of treatment options, so that most respondents felt that they could choose the groups they needed/wanted for their own recovery.
- **Recovery Orientation** – Over 90% of respondents agreed that the programs and staff encourage them in their recovery through their use of positive language. Eighty-six percent of all respondents also agreed that staff encourage them to try new things and convey their belief that respondents can recover.
- **Benefits of Peer Specialist** – Seventy-five percent of respondents at all programs reported that they had worked with the peer specialist. Most (83%) of those that had worked with the peer specialist reported that the peer had helped them.
- **Rights, Respect, Crisis Instruction** – Nearly all respondents (92%) agreed that staff had informed them of their rights at the program, and most respondents agreed that the staff does not use any form of coercion with them (94%). Nearly all (95%) agreed that they know what to do in a crisis situation at the program or outside of the program.

Key Areas of Need

- **Discharge Planning** – Less than half of all respondents (48%) reported that the criteria for discharge from the programs had been clearly defined and discussed with them.
- **Community Connections** – Less than 70% of respondents agreed that staff encourage their involvement in non-mental health related activities outside of the program. Less than half of the respondents (47%) agreed that the program brings in people from the community to explain their services.
- **Peer Component Meeting Performance Specifications-** the 12 programs provide varying structures for the peer component, some have a peer specialist on staff at least half time,

[1] Eight programs had a peer specialist at the program at least 3 hours/week. The other four programs had groups led by current or former clients or peer volunteers.

others have a peer specialist for a few hours a week, and several utilize clients, former clients or volunteers to run peer led groups. Greater involvement of peers in providing recovery services would be good, and peer leaders should receive formal training; peer leaders should receive regular supervision by program staff.

- **Post-program Productive Activity –** Despite reported improvements in their mental health and hope for the future, less than half (47%) of respondents reported any improvement in their ability to hold a job or volunteer position since entering the programs. This is a complex issue, but one that programs could address more directly with clients.

Recommendations

- Build on the existing strengths of treatment planning, recovery orientation and choice at each program to work with clients early on to plan for their moving on from day treatment. Build into the programs' a "language of discharge" so that discharge criteria and issues become part of the overall program orientation for staff and clients.
- Build on staff relationships and recovery orientation to help clients consider various ways to connect to their communities while in the program. This will help clients use program supports to navigate the challenges of moving back into the community.
- Increase client exposure to peer specialists, particularly their hours of availability. Expand the role of the peer specialist beyond facilitating groups to providing individual recovery support and to help assist clients in making the transition out of the day treatment program and into another productive activity.

2	SURVEY METHODOLOGY

Interviewing Protocol

Interviews were conducted in person at each program. Specific dates for the interviews were arranged in advance. The approximate length of each interview was 30 minutes.

Survey Instrument

CQI staff met with MBHP staff to determine the objectives of this evaluation. MBHP identified two core objectives: learning about the experiences of clients with regard to the programs' incorporation of recovery oriented principles and the clients' experiences with the peer led services at the programs. CQI developed a survey that incorporated questions from the previous day treatment surveys as well as questions from the Recovery Assessment Scale[2], and some additional questions based on MBHP's priorities.

The enhanced day treatment survey instrument consists of 32 quantitative and 11 qualitative questions, as well as 15 demographic questions (Appendix A). Most quantitative questions allow individuals to respond using the five point scale seen below. (Most questions also contained an additional point with a "not applicable" ("n/a") option.) Four questions had a two-point, yes or no, response option. Interviewers also recorded respondent's comments to some of the quantitative questions to allow for better interpretation of these variables.

1	2	3	4	5
Strongly Agree	Agree	Not Sure/Neutral	Disagree	Strongly Disagree

In addition to the quantitative questions, eleven open-ended questions were asked throughout the interview. Interviewers recorded responses to open-ended questions using respondents' own words as much as possible, though longer responses were sometimes paraphrased.

Reporting Data

Below is an example of how responses are reported for the quantitative section of the survey instrument. We have included a discussion section following, which describes the comments respondents gave in this section of the survey.

The percentages for each response category are listed under the variable label. The total number of respondents for this question is 20 (N).

SAMPLE TABLE

	1 Strongly Agree	2 Agree	3 Not Sure /Neutral	4 Disagree	5 Strongly Disagree	N
Staff encourage me to take risks and try new things	20%	60%	10%	5%	5%	20

[2] See eg, Corrigan PW, Salzer M, Ralph RO, et al: Examining the factor structure of the Recovery Assessment Scale. Schizophrenia Bulletin 30:1035–1042,2004

3	SITE DESCRIPTION

Program Type: Enhanced Day Treatment Program

Enhanced Psychiatric Day Treatment has the same goals, structure, and modalities as Psychiatric Day Treatment with the addition of peer specialist services. Day treatment programs, in general, provide rehabilitative, pre-vocational, educational, and life-skill services to promote recovery and attain adequate community functioning, with focus on peer socialization and group support. Providers are expected to ensure that the Member has opportunities and support for involvement in community, social, and leisure-time programs, as well as opportunities to pursue personal, ethnic, and cultural interests Active family/significant other involvement is important unless contraindicated.

The peer specialist services must meet the following four criteria:

- Consumer leaders will have participated in a program to train peers to lead/co-lead groups and to promote wellness and recovery.
- Peer-led support services will be provided by a trained peer counselor for a minimum of 3 hours/week.
- Trained consumers will be part of the staffing requirement of the program.
- Consumers who deliver peer services as part of an Enhanced PDTP will receive support and ongoing supervision from program staff.

Overview of services offered:

CQI interviewed 270 consumers at 12 Enhanced Day Treatment programs throughout the state.

Eight of the 12 programs had the services of a peer specialist at least 3 hours per week. Some of the peer specialists at these eight programs were on staff, some were former clients at that program, and some were hired from another agency to provide peer services/groups at the program.

Three programs had a peer specialist working 3-4 hours per week; three programs had a peer specialist working between 15-20 hours per week, and one program had a full-time, 40 hour per week peer specialist[3]. Additionally, there was one program that had a peer specialist who runs groups one day a week and is available to consult with staff.. The remaining 4 programs provided peer-led groups run by clients currently in the program, former clients or volunteers.[4] Some consumers at programs with peer-led groups understood that the opportunity to lead a group was also available to them.

[3] Not all peer specialists were certified.
[4] Not clear that all of these group leaders had received training or were receiving supervision.

4	DEMOGRAPHICS

Two hundred seventy clients (N=270 at twelve enhanced day treatment programs were interviewed between January and April 2009.

Age (N=262)	
Mean	43 yrs
Median	45 yrs
Range	18-68 yrs
Gender (N=267)	
Male	38%
Female	63%
Race (N=264)	
African American/Black	9%
Caucasian/White	77%
Native American	2%
Multiracial	2%
Other	11%
Ethnicity (N=261)	
Hispanic/Latino	9%
Physical Disabilities (N=258) *Could chose more than one*	
None	57%
Loss of mobility	12%
Loss of sight	7%
Loss of hearing	3%
Any other disability	21%
Work Status (N=259)	
Working for pay: part-time	8%
Volunteer work	9%
Not working for pay	80%
Decline to answer	1%
Other	2%
Primary Emot. Supp. (N=263)	
No one other than self	10%
Family/Significant other	39%
Friends	11%
Legal Guardian	1%
Case Manager	4%
Therapist	24%
Decline to Answer	2%
Other	9%

Primary Language (N=266)	
English	93%
Spanish	3%
Portuguese	1%
Other	3%
Housing Situation (N=264)	
Live alone	30%
Live with spouse/significant other	6%
Live with family	27%
Live in group home/nursing home	15%
Live in supported housing	13%
Live with roommates	5%
Other	3%
Education Completed (N=265)	
8th Grade or less	5%
Some high school	13%
High school graduate/GED	40%
1-3 years of college	26%
College graduate (4 years)	13%
Other	3%
Relationship Status (N=263)	
Single/ Never Married	65%
Married or Living as Married	7%
Divorced or Separated	25%
Widowed	2%
Other (Significant Other)	2%
Respondents with Children (N=265)	
Living with them at least part time	16%
Physical Health (N=264)	
Poor	13%
Fair	36%
Good	42%
Excellent	9%
Time Attending Program (N=262)	
Mean	27 Mos.
Median	9 Mos.
Range (in months)	0-384

Almost two-thirds of the respondents were female and over three-quarters were Caucasian. Very few were married or working for pay. Eighty-two percent had at least a GED and more than one-third attended college for some period of time.

There was a notable difference in the mean and median length of time in program. While 50% of the respondents had been in the program 9 months or less, the average length of stay was just over 2 years.

5 QUANTITATIVE RESULTS

Results

Treatment Planning						
		No	Yes	Don't Know		N
Has a treatment plan		6%	84%	10%		266
	Strongly Agree	Agree	Not Sure/ Neutral	Disagree	Strongly Disagree	N
Staff listen to and follow my choices in treatment planning	44%	47%	6%	3%	1%	267
The program makes every effort to involve my significant others in the planning of my services	22%	48%	17%	10%	3%	208
I am able to choose from a variety of treatment options at this program	40%	49%	5%	5%	1%	265
Staff assist me in developing career and life goals beyond symptom mgmnt and stabilization	27%	55%	8%	9%	1%	260
The achievement of my goals is formally acknowledged and celebrated by staff	33%	57%	6%	3%	2%	267
Staff Motivation/Encouragement						
Staff use a language of recovery (hope, high expectations, respect) in everyday conversations	41%	50%	5%	3%	1%	268
Staff encourage me to take risks and try new things	33%	53%	9%	4%	0%	264
Staff believe I can recover and make my own treatment and life decisions	38%	48%	11%	3%	1%	267
I am/can be involved with program staff in the development of new services	28%	52%	14%	6%	0%	238

Community Connections	Strongly Agree	Agree	Not Sure/ Neutral	Disagree	Strongly Disagree	N
There has been enough coord. between day treatment staff and my other providers	28%	49%	12%	8%	4%	258
Staff play a role in helping me to become more involved in non-mental health related activities	20%	48%	13%	15%	4%	236
This program attempts to connect me to self-help, peer support, and/or consumer advocacy groups	34%	42%	11%	13%	1%	218
This program brings in people from the community to explain their services	13%	34%	21%	27%	5%	260
Crisis Intervention						
Staff are available when I'm in a crisis situation during program hours	57%	38%	3%	2%	0%	266
I know what to do if a crisis occurs after program hours	44%	50%	3%	2%	1%	267
Rights						
Staff have informed me of my rights at this program	43%	49%	6%	3%	0%	268
Staff do not use threats, bribes, or other forms of coercion to influence my behavior or choices	61%	33%	2%	3%	1%	265
Cultural Competence						
Staff are diverse in terms of culture and ethnicity	25%	46%	14%	14%	1%	258
Peer Services						
		No	**Yes**			**N**
Have you worked with the peer specialist here		25%	75%			263
Would you like to work with him/her		30%	70%			66
Has the peer specialist helped you		17%	83%			223
	Not Enough	**About the Right Amt**	**Exact Right Amt**	**Too Much**		**N**
How do you feel about the amount of time you have spent with the peer specialist	25%	60%	14%	2%		220
Discharge Planning						
	Strongly Agree	**Agree**	**Not Sure/ Neutral**	**Disagree**	**Strongly Disagree**	**N**
The criteria for being discharged or completing the program has been clearly defined/discussed with me	19%	29%	19%	27%	7%	258

Outcomes of Services

Respondents rated the degree of improvement in certain areas of their lives in the last year, or since beginning to receive services at the program.

Outcome	Worse	Same	Better	Much Better	N
Mental Health	2%	17%	50%	31%	262
Ability to cope when things go wrong	2%	23%	49%	26%	263
Involvement in daily activities	4%	32%	43%	21%	259
Ability to hold a job or volunteer position	7%	46%	29%	18%	235
Hope for your future	4%	16%	37%	44%	258
Relationship with family	8%	30%	33%	29%	253
Relationship with friends	4%	35%	40%	21%	248

Improvement in any of the outcome domains was determined by totaling the percentage of respondents that answered "better" and "much better" to the outcome questions. More than 60% of respondents reported improvement in all outcome domains except for the *ability to hold a job or volunteer position* (47%). Respondents reported the most improvement in the areas of *mental health* (81%) and their *hope for the future* (81%). In addition to the *ability to hold a job* category, the least amount of improvement was reported in the areas of *relationships with family* (62%) and *friends* (61%).

Crosstabs procedures were run on the outcome variables to determine if there were any differences in outcomes based on length of stay in the program and education level. Length of stay was dichotomized by the median (9 months) and education level by high school degree or less and some college or more. There were no differences in outcomes based on the level of education of the respondents. Those in the program for less than the median amount of time reported improvement in their *hope for the future* while those in the program longer than the median length of stay reported improvement in their *relationships with family.* From our data we are not able to accurately identify what percentage of those who responded "*Same"* were satisfied with their family relationships and, therefore, not working on improving them.

It may be that those who are new to the program report greater hope for the future because of the relief and positive feelings they experience when they begin to actively engage in their recovery. Those in the program longer than the median length of time may report better family relationships because they have achieved some stability and some skills for enhancing family relationships. They are no longer in the active throes of their illness which makes relating to family in a positive way easier and more satisfying.

Additional crosstabs could not be run on gender and nature of the peer component because the representation in the two categories for each of those variables was quite skewed.

6 QUALITATIVE FEEDBACK

Comments in Response to Quantitative Questions

Respondents sometimes provided comments in support of their quantitative response. This kind of information allows us to better interpret the hard data and provide more specific explanations of why a certain trend is taking place.

Respondents were asked for an explanation when they provided a response indicating disagreement or uncertainty (a response of *not sure/neutral*).

Respondents also offered comments spontaneously, without prompting from the interviewer, and these comments were recorded.

LENGTH OF TIME BEFORE TREATMENT PLAN DEVELOPED
Seventy-eight percent of all respondents answered the question *"About how long were you at this program before you began working on your treatment plan?"* Of that number, more than half said that they began working on their treatment plan within the first week of their arrival at the program. An additional 20% of respondents to the question reported that their treatment plan was developed within the first month of their program. Less than 10% of those who responded to this question reported that it took longer than six months to develop a treatment plan.

INVOLVEMENT IN DEVELOPING NEW SERVICES
Respondents were asked to give an example of a time they were involved in developing new services or programs at the day treatment program, or to explain why they feel this involvement is possible. The following themes emerged from the responses to this question.

Client can Suggest
About half of the respondents indicated that the opportunity for involvement was there if they were interested. They appreciated the staff openness to their suggestions, but often they described their involvement in passive terms – making suggestions, but not having any direct input.

> *If I have an idea for a group I can bring it to the director. She may or may not use it.*
>
> *…if the clientele needs something, they would take it under consideration. They would discuss it among themselves*
>
> *Three months ago they asked for suggestions of groups and anger management, which they started.*

Staff Decides

Several respondents across programs reported either that they had no say in developing new services, or that they did not want to be involved as they saw service development as a staff responsibility.

> *I'm not involved in that. I'm not asked to be involved.*
>
> *I don't feel it's my place to be involved in administrative decisions or anything like that.*
>
> *The decisions are only staff based.*

Client Actively Involved

Several respondents across programs reported that they had displayed agency – beyond making a suggestion – in initiating new services for themselves and/or the programs.

> *I really pushed for the staying sober early recovery group. I redid one of the group rooms.*
>
> *I asked for an anxiety, anger, and courage groups and got them.*
>
> *I make myself involved. I just think you got to be an activist in this program or you get overlooked.*

INVOLVEMENT IN NON-MENTAL HEALTH ACTIVITIES

Less than 70% of respondents agreed that staff play a primary role in helping them become more involved in community activities. Those respondents that commented on their disagreement with this statement said things like:

> *I felt my outside stuff wasn't a priority*
>
> *Basically, they stick with what goes on here. They talk about it but don't suggest things to do on the outside.*
>
> *I need to become more involved in social things. They agree but don't help me find anything.*
>
> *I have to do this myself.*

BRING IN PEOPLE FROM COMMUNITY TO EXPLAIN SERVICES

Less than half of respondents (47%) agreed that the programs brought in people from the outside to explain other services. Several respondents' comments demonstrate why this is an important service to offer day treatment clients.

Treatment [is] geared towards being here…A lot of people need housing help but no agency people come in. It would be good because it's hard to take initiative.

We need stuff like that. I've been trying to get fuel assistance. I don't know where it's at.

I would like to see the staff implement more outside things to help us with our daily lives. They don't have any people come in right now. Fuel and heating assistance. Places that can help with rent subsidies, career assistance, child care.

[I] would like to learn more about help in the community for abused women and children.

They brought in career resources before it was closed down – but it would be helpful if they had other people from other programs come in – food stamps, fuel assistance – to talk about the application process

DISCHARGE CRITERIA HAVE BEEN EXPLAINED

Less than half (48%) of respondents across all programs agreed that the discharge criteria had been clearly defined and discussed with them. Two themes emerged from the comments respondents made in relation to this question.

Consumer Reluctance

The first was that some consumers are reluctant to discuss or explore discharge.

I'm not ready to discharge yet. When the time comes I will seek out more

I haven't found out about that. I plan to be here for a while. That's part of my plan.

No comment. I don't want that to happen.

I and my coordinator have never talked about me leaving. It's never come up and I think that's a good thing.

No Substantive Discussion

The other theme is that staff has not engaged consumers in a real discussion of discharge criteria. What clients know about discharge is often a result of implication rather than discussion.

It seems to be a difficult thing to get a definite answer about. I don't know why that should be the case, but it's been my experience that you have to be quite assertive and know when you're ready to make change and move on to the next level.

There is no end in sight. There is no discussion about what it means to be in a good space.

They didn't tell me what my discharge plans are, or what's the point I'm supposed to reach.

Although I know how it's done, they don't explain that. They work with the here and now.

Responses to Open-ended Questions

We included in the survey five open-ended questions to allow respondents to offer, in their own words, feedback on the services provided and suggestions for improvements.

PROGRAM EXPECTATIONS
In response to the question, *"What do you hope to get from coming here?"* the following themes emerged. Many respondents mentioned more than one issue/reason for coming to the program.

Better Mental Health
Respondents at all programs said that they were at the day treatment center to get help with their mental illness/substance abuse. For some, this meant learning more about their illness and how to manage it; others were seeking help in managing specific symptoms.

Learn more about my illness and how to manage them [sic] by being compliant with my meds. I want to be able to identify and explain things to a doctor so he can better talk with me.

I hope to get a better mental focus and eventually to be rid of my depression altogether.

I hope to get sobriety and continue learning DBT skills to learn how to handle my psychosis.

Trying to get an emotional balance. To deal with all of this better. To control my anxiety. To see if I can adjust to society.

Structure
Respondents at all but 2 programs specifically stated a need for more structure in their lives and the program offered them this structure.

One thing is structure for the present. Structure to help figure out the rest of my life.

A structure of life, I didn't have much before I came here.

Being here keeps me out of trouble, gives me structure.

Enough structure and support to get stabler and remain stable …

Skills

Respondents at three-quarters of the programs stated they were hoping to learn or hone skills – coping skills, relationship skills, and general skills for living.

> *I want to learn how to cope with certain things in life and learn more about human nature and relationships. I also want to learn some coping skills and how to deal with my own issues.*
>
> *Skills that will help me return to a more normal life.*
>
> *Help with my hygiene, social skills, so I can be a better person on the outside.*
>
> *I hope to learn new positive coping skills that I failed to learn in the past.*
>
> *I was an addict, so basically keep me in a life style that is clean and sober and coping skills for not using every day.*
>
> *Coming here and getting skills. How to deal with it. Communication skills, relationship skills.*

Socialization

Respondents at three-quarters programs mentioned their desire for increased socialization as a reason for their participation in the program. For some the opportunity to socialize also meant they could develop confidence within a safe environment (the program).

> *Learn how to socialize with people.*
>
> *I hope I will feel more comfortable around people …*
>
> *I like the socialization here and the opportunity to know I'm not alone.*
>
> *I'm getting out more, talking in groups, participating. I don't stay at home and isolate.*

Achieve Vocational/Educational Goals

Respondents at two-thirds of programs hoped that the day treatment program would help them move toward their goal of achieving life goals and engaging in productive activity. For many this meant a return to part-time or full-time work, for some it meant engaging in volunteer activity, and for others it meant furthering their education in the short run so that they could get a job in the future.

> *I'm working to go back to school.*
>
> *To become stable enough to eventually go back to the workforce.*
>
> *To get back in the situation of being capable of getting back to work.*

I hope to be able to volunteer someplace.

Someday I might want to go back to school and get my GED, get a job, and stay clean.

Support
Respondents at half of the programs stated that they hoped to get some kind of support from the programs. For some this was generalized support, for some it was the support of their peers. Some respondents were looking for support that would help them move forward in their lives.

Already I have gained support from other people with their insight of daily struggles.

More emotional support and peer support.

Just with support from staff with everybody, believing in myself.

The support of people with similar problems as mine

I want a community of support. I'm closer to the people here than the majority of my friends.

HOW ELSE COULD STAFF BE HELPING WITH GOALS

Respondents were asked *"What else could staff be doing to help you reach your goals?"* Three themes emerged across all of the programs.

Staff Doing All They Can
The majority of respondents across programs said that staff was doing all they could to help them. While this indicates appreciation for the work the staff does, it is difficult to interpret since respondents also want more time with and more direction and understanding from staff (see next topics).

Greater Staff Availability and Direction
Respondents at half of the programs also stated that they would like more individual time with staff. Some respondents identified specifically what they wanted from this contact, some just wanted more individual time.

Staff could give me advice on how to better myself.

More one-to-one contact. Talk with me more.

My coordinator could sit down with me more and go over my long-term outlook. What I expect and what they expect for me to get out of this.

More one-on-one time. It helps to be able to talk to them one-on-one instead of in a group.

Individual Needs and Goals
Respondents at half of the programs wanted more help in working toward their personal goals. These respondents also wanted more understanding from staff of their particular needs.

Help me define and set my goals, not their idea of what I should work on.

Tell me what I'm working on everyday. To remind me every morning what goals I need to work on.

Set up a small part-time job.

Individually design homework related to my treatment plan. I think it would help me achieve the goals in the plan.

PEER SPECIALIST

Three quarters of clients across the 12 programs reported that they had worked with the peer specialist or participated in one of the peer-led groups and 83% of these respondents found their work with the peer to be helpful.

Information about Peer Specialist

Respondents were asked *"What has the staff told you about the peer specialist (his/her role)?"* The following themes emerged from the responses.

Told Nothing
When asked this question, respondents at 10 of the 12 sites reported being told little or nothing about the peer specialist/peer leaders.

Has a Mental Health Condition
Respondents at two-thirds of the programs stated that the peer had also experienced mental illness or addiction. They understood that the peer was "like us". In some instances the peers had explained their status as consumers, in others the respondents had surmised this without a clear explanation from anyone.

They mentioned that s/he had been mentally ill.

S/he's like me. S/he's mentally ill, but she can cope with her mental illness and help people who are sick.

S/he brings his life experience to the groups here and understands more what's going on with people since s/he's been through it.

S/he just basically told us about him/herself; s/he's had mental illness her/himself and shares some of her/his story – with hard work and treatment you can make something of your life.

S/he always lets you know his/her history and where s/he's coming from. S/he works to coordinate your feelings with someone who understands because s/he's been through it.

Group Leader

Respondents at about half of the programs described the role of the peer as someone who led groups. Respondents at programs that had peer-led groups rather than a peer specialist understood that they, too, could run groups.

S/h*e's a volunteer group facilitator.*

If someone has an interest or skill they want to share, we talk to staff and they approve it.

The peer has to come up with the idea.

They introduced him/her, they said s/he would run certain groups.

Benefits of Peer Specialist

Respondents were then asked to explain *how the peer specialist had helped them and what the peer specialist adds to the program.* Several overall themes emerged across programs.

Model of Hope and Recovery

Respondents in all but one program stated that the peer specialist/peer-led activities provided them with a model of hope and recovery.

It makes you feel positive. As if I can try anything I want.

Hope … that you can achieve some of your goals.

S/he gives a sense of hope that there is life after having a mental illness.

It shows that you can come out of your mental illness. It gives you hope.

It adds a person that's on staff that's not just staff but a consumer like the rest of us. S/he's able to function outside of here –s/he brings hope.

Unique Understanding

In addition to offering hope to program participants, respondents in more than three-quarters of the programs talked about the peer's ability to understand their struggles in a meaningful and unique way.

> *Gives you somebody to talk to who understands exactly what you feel – somebody who can relate to what you are talking about.*
>
> *S/he helps us move forward. Peers know what is going on better than the professionals.*
>
> *Someone who understands firsthand what you're really going through.*
>
> *I think it adds more of a sense of reality. Some of the counselors went to school. They do it by the book. But the peer specialist adds the perspective of someone actually living with addiction or mental illness.*
>
> *They do a good job adding personal experience.*

Approachability

One benefit of the unique understanding that the peer specialist brings to the program is his or her approachability. Respondents noted that they could and would talk with the peer about things that they would not discuss with staff.

> *… everyone can open up and can talk without being anxious or nervous to talk.*
>
> *Sometimes people who don't want to go to staff can go to the peer specialist with a different understanding.*
>
> *It's a person that I feel I could speak to about my mental illness and feel safe and secure.*
>
> *… some consumers say they are more comfortable talking to the peer specialist than they are to staff – especially about drug and alcohol issues.*

Promote Connections among Consumers

Another benefit of the distinctive position of the peer specialist and the peers leading groups is that they are able to promote a sense of community among participants and in the programs as a whole.

> *It adds a segue to connect the clients and staff. He's both. So it shows there is not a complete wall between us.*
>
> *It gives the consumers a feeling of being helpful with each other because they strongly emphasize the community.*

Stronger sense of community to group as a whole when you are connected to one another.

Information and Resources

In about half of the programs respondents noted that the peers provided them with valuable information about community resources. The peers were both knowledgeable and connected and participants benefited from this.

S/he's always got announcements [about community opportunities and services]. S/he has all this information and puts it up on the board...

Knowledge, s/he has knowledge of what I need and about the insurance.

S/he's a resource for different community issues.

Having [a peer specialist] makes me aware of what is going on in the community and you can get help both physically and mentally.

Peers Benefit from Providing Services

Respondents in programs with groups run by current or former clients also spoke consistently about the benefits reaped by the peers who led the groups, rather than how the programs/respondents benefited from the peer services. These benefits included increased self-esteem and self-confidence and an opportunity to develop new skills.

I like having a peer-led group. It develops leadership… when we do the new schedule I'm going to run a peer-led group.

A chance to further your skills and further yourself. Build self-confidence and self-esteem.

It adds variety. If I wanted to do a group I could; it's open to anyone.

It helps people take charge of situations and events by taking charge at meetings.

It gives people a sense of being able to do things on their own – empowerment.

DISCHARGE PLANNING

Respondents were asked two questions about their discharge planning. The first had to do with staff help and support in developing the plan. The second focused on what respondents thought they needed in order to feel ready to transition from the program.

1. Development of Plan

Respondents were asked *"In what ways have staff been working with you to develop your discharge plan?"* This question was the most difficult for respondents to answer. Three-quarters

of respondents gave a substantive answer to this question. The following themes emerged from those responses.

No Discussion

Over half of the responses indicated that respondents did not perceive the staff to be working with them on developing a discharge plan. Some of these respondents were new to the programs and answered *"Not yet"* to this question. Others responses included the following:

> *The discussion is not happening.*
>
> *It seems to be a difficult thing to get a definite answer about.*
>
> *Staff has not assisted in helping me decide or telling me the criteria.*
>
> *No one ever talked to me about it.*
>
> *Although I know how it's done, they don't explain that.*

The remaining responses described levels or stages of help that staff was providing in preparation for discharge.

Encouragement

The first level of help that respondents reported receiving was encouragement in their work in the programs.

> *They say to come every day, don't be absent. They give us a boost, positive things.*
>
> *Well, making sure I'm on time. Going to programs I'm supposed to be going to. Keeping my attendance up.*
>
> *They have given me encouragement, although I'm not all better yet. They help me be realistic about my goals.*
>
> *They have evaluated my progress and evaluated areas [that] still need work.*

Preparation

Another way that staff helped respondents move toward discharge was through preparation for life outside of the program through the group work and through ongoing discussions of discharge plans and needs.

> *It's more of a group effort to decide when it's time to go. They discuss goals …*
>
> *See my MD's. Keep my appointments, take my meds.*
>
> *In helping me with my skills and giving me homework.*

One of the things we're putting together is after care programs I might be involved with…They wean you off the program

They are trying to encourage me to look for volunteer work.

Set and Meet Goals
The most direct staff help that respondents reported was assistance in setting and meeting their goals. Sometimes this involved specific services needed to meet goals.

They helped me set up and reach my discharge goals…And to use the skills that I have learned here.

They're helping me get housing through another company and getting transportation to school.

By setting up short-term and long-term goals.

They help me with specific goals. They help me on jobs and focusing on what I want.

2. Necessary Transitional Support
Respondents were then asked *"What do you think you need to have in place in order for you to feel ready to transition from this program? (What kinds of support from other people or groups are important for keeping you well?)* About half of the respondents identified more than one need, some as many as three or four.

Formal and Informal Support
Respondents at all programs identified some form of formal or informal support that they would need in order to transition from the day program. Formal supports included professional supports such as: counselors; case managers; agencies like Mass Rehab; and other formal programs.

Need to have a therapist, psychiatrist. Have a general safety plan that can be used in any situation…my DMH worker.

AA, NA, my case worker, my therapist.

Find me another program with structure.

I need individual therapy and a psychopharm. Structure, such as taking classes at ___

I'd probably have to find an outside support group.

Informal supports included family and friends and other non-structured activities in the community.

I think the thing that keeps you going is having people there for me. Helping you over rough spots, or I'll call you every night. Someone to be there. It'll be like a buddy system.

I have two sisters that are nurses that are supportive.

I need to find a way to develop more community supports.

I've been looking for a church to go to but I don't have transportation.

More friends that I can talk to ... I've been a loner all my life.

Stable Mental Health

Respondents at three-quarters of the programs identified particular milestones in their recovery that they wanted to achieve before their discharge.

My drinking and alcohol abuse…that I be clean and sober for awhile.

I need to learn how to cope better with my voices and hearing things and how to act socially with other people and not stick out.

Sobriety to be under wrap...

… to remain stable, be med compliant, to be able to identify and focus when I'm having symptoms.

Being able to deal with my stress and my depression and my learning disability.

Productive, Structured Activity

Respondents at two-thirds of the programs stated that they would need to be engaged in some form of productive activity that helped them structure their time. Productive activity included full-time or part-time work, volunteer work, educational pursuits and structured programs.

A part-time job, 10-15 hours per week. Possibly a class at UMass Boston.

I would like to have a volunteer job, but before that I would like to volunteer and come here, work towards discharge – continue coming but reduce the frequency.

One of my requirements is to have a volunteer position in place so that I'll have some daily structure in my life.

I would have to have something else in place, going back to school, part-time job, volunteering.

Somewhere to go during the day – a job or volunteer position or school. More depends on the outside.

MOST HELPFUL SERVICES/SUPPORTS

Respondents were asked *"What service or support at the day treatment program has been most helpful in your recovery?"* The following themes emerged from the responses to this question.

Groups

Respondents at all of the programs identified the groups as the most helpful service they received at the program. Two types of groups were mentioned specifically across programs as being most helpful – DBT groups and the dual diagnosis groups.

The groups. Being in a group and hearing other people's stories and comparing experiences has been very helpful.

When I get a chance to talk in a group, especially a small group, I feel more comfortable. In the small groups I can speak up and that helps.

Groups have been very helpful in learning and understanding about mental illness and being able to deal with them.

The DBT group – it helped me immensely. It focused on helping you deal with self-harm issues as well as self isolating, building mastery, learning how to deal with stress and intense emotions and make more rational decisions.

Dual recovery group because it tells me that my bipolar could affect my addiction behaviors and how addiction can be part of my mental illness.

Staff Support

Respondents at two-thirds of the programs stated that the support they received from the staff was the most helpful aspect of the program.

Having the advocate to go to with questions and problems – because you have someone to listen and be there for you.

Staff support is excellent, whoever is available will help me.

I really like my coordinator. I like talking to her when times are really tough. She's been helpful.

Them listening to me and guiding me into the groups and being patient.

Talking about my problems and having them have an open ear and the feedback that they can give you.

Peer Support

Respondents at more than half of the programs identified peer support as the most helpful part of the day treatment program.

Peer support. I really like that group because it's people with the same problems. If you need to talk they can relate and help with the problems.

Probably peer support …being with my peers and having the groups.

Peer support. You know that they have problems, too. It's good to get support from them rather than the facilitators.

Peer support has been the most helpful in my recovery.

WHAT WOULD CHANGE ABOUT PROGRAM

Respondents were asked *"If you were in charge of this program, what is the first thing you would change?"* The following themes emerged from the responses.

Change Nothing

Almost one quarter of all respondents said that they would change nothing about the program and that for them it was working.

I am very satisfied and don't know what I would change.

I really wouldn't change anything.

I'm pretty satisfied, no complaints.

Groups

Respondents at 10 of the 12 programs suggested changes to the groups at their programs. Some wanted new groups added, others wanted existing groups eliminated. Some wanted larger groups, others wanted smaller groups where they would find it easier to speak up. Respondents wanted groups that would offer specific skills for future independence or groups that had a less demanding and more relaxing focus.

Step it up a little. Some of the groups aren't challenging enough. There's more kiddie stuff than real work being done.

We need a crisis group… I mean a group for people who are having a hard time and who can't sit in a regular group.

I would change some of the groups. Come up with different groups. The groups are good, but try something different..

I would add some groups, like smoking cessation, art, group therapy, friendship group.

The amount of people in each group. Groups are kind of crowded.

Staff

Respondents at about half of the programs said that they would make some changes in the staff. Many said they would add staff, some said they would add more male staff or more diverse staff. Some respondents wanted to increase the amount of direct one-to-one contact they had with staff.

I think I would look at the dynamic between staff and consumers, how to empower consumers by offering more venues to advocate for yourself.

The staff. I'd have a few men – it would be a challenge to trust men, and it would be good for me. If there was a black staff maybe they could understand.

I wish we had a RN on site so that we'd know about all the side effects of the prescription drugs.

I would have staff check in with their clients at least once a week and be there for them.

The staff. Try to understand our problems better. Don't treat us like children. Understand we are all different.

Time, Physical Plant, Food

A small percentage of respondents across programs suggested changes in time factors of the programs. Some respondents referred to the length of the program day, some referred to the length of the groups or the breaks between groups. A few wanted the program to run on the weekend.

I would change the down time – make breaks ten instead of fifteen minutes.

The lunch hour – it's awful long – I would add a thirty-minute group in there.

Respondents at several programs said they would make changes in the physical plant – the size of the rooms, the temperature of the rooms, the paint, furniture and overall physical appearance of the space.

The paint. I'd just paint the place all different colors. The room sizes.

Turn the heat on higher.

The heat in this building. It's awfully hot. I think people concentrate better when the temperature is right.

Respondents at several programs made suggestions related to the food and beverages at the programs, including coffee, breakfast, lunch, and healthy snacks.

I would change the food. The food isn't as good as it should be.

Get better soda machines and snacks.

It would be a bit better if they gave out breakfast.

7 DISCUSSION

- Groups are the mainstay of the services offered at the enhanced day treatment programs. Survey respondents are generally satisfied with this format and with the variety of topics offered in the groups at each program. The most popular groups across programs are the dual diagnosis groups and DBT groups. The groups offer consumers the opportunity to learn about mental illness and its management, coping and living skills, and creative expression. In addition, the groups offer participants a chance to interact with others who understand their struggles and to expand their social capabilities to include speaking in groups.

- Respondents valued the support they received at the program from peers and from staff. The sense of community at the programs was fostered by acceptance, understanding, and mutual support.

- Ninety-one percent of consumers agree that staff use a language of recovery and 86% agree that staff believe they can recover from their mental illness/addiction. On the other hand, these programs do not consistently incorporate clear language and direction around discharge planning. It seems that discussions around discharge are either unclear or not happening consistently. This suggests that recovery is an idea that is discussed, but not one that the programs help consumers operationalize in their lives beyond the program. Programs would benefit from developing and using a clear and direct "language of discharge". This should be paired with guidance on living a quality life in the community.

- While the day treatment programs provided a safe environment and helpful services within the confines of the program, they are insular in nature and not well-connected to the broader community. Consumers are thus often left to make these connections on their own or

through their other providers. Program clients may be missing out on opportunities to build bridges to the larger community.

- There was wide variation in respondents' readiness to move forward and think of life beyond the program. Programs that build in more community connections through speakers and through community activities offer the scaffolding that most consumers need to venture into and become part of their larger community. Additionally, programs could make better use of clients' support systems in the community, including their family and friends.

- Respondents generally spoke highly of the peer specialists, as models of hope and recovery who can provide a unique understanding based on their lived experience. Nevertheless, the role of the peer was not clear to many clients, especially those in programs with the minimum level of peer specialist services.

- Peer specialists also functioned as effective bridges to the broader community. They provided consumers with information about services, opportunities, activities and programs in the community. They can serve as a valuable resource for programs seeking to build stronger connections to the community for consumers. We suggest that peer specialists be introduced as members of the program staff and their role should be clearly explained to all program participants.

- Additionally, peer specialists are a valuable resource for staff and should be used for staff development and education, particularly around recovery oriented principles. Rather than having the peer specialist as an "add-on" component, programs should consider the peer specialist as a part of the program, and this should involve having the peer specialists attend staff meetings and receive supervision.

- The peer component of the twelve enhanced day treatment programs varied greatly. Some had a peer specialist on staff, but the number of hours the peer specialist worked varied significantly. Other programs utilized clients, former clients, or volunteers to run peer led groups. While there are benefits that clients reported from each of the various peer structures, we found that the limited number of hours at some programs created real limits on the peer specialist's ability to have the time to work effectively with clients on their recovery goals. And the groups serve a great purpose, but the peer specialist role was developed so that peers could use their life experience and training to work with individuals.

- While we did not analyze how successful the peer specialist was integrated with the other staff, we have previously conducted a case study of a day program in Massachusetts that successfully integrated the peer specialist with really nice results. (See CQI report: "*Case Study of Factors Contributing to the Successful Integration of a Peer: Specialist into a Day Treatment Program*" at **http://www.cqimass.org/pdfs/PS%20Day%20Treatment%20Case%20Study%20Final1.pdf** and attached.)

- Many respondents recognized the personal advantages to be gained from leading a group at the program. They identified increased self-esteem, leadership development, empowerment and self-confidence as some of the benefits of running a group. The skills gained from the experience can translate into life beyond the program. The opportunity to lead a group as a peer is a great way for programs to support recovery and growth in consumers. All programs – even those with more than the minimum peer specialist services – should offer the opportunity to lead a group for those consumers that are interested in doing so.

CQI has completed aggregate reports on day treatment services in 2001, 2003 and 2009.
Our 2001 report noted two ways in which day treatment programs could better address the long-term needs of program participants. The first recommendation was to incorporate peer specialist services into the program as a way to promote recovery. The second was to build more community connections to decrease the isolation of the program and to promote ongoing recovery by connecting consumers to activities outside the program. There has been movement on the first recommendation, but little on the later. One problem is that the programs are not permitted to provide employment supports; that can be changed through a Medicaid Waiver, and should be.

8	APPENDIX

A. Blank Outpatient Survey

B. Comments to close ended questions

C. Comments to open ended questions