IRIS Fellowship Research Project Write Up

Research Project Title: Assessing the Ability of Peers Working at Recovery Re-entry Homes to Administer a Validated Measure for Activities of Daily Living

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Introduction

The Important Role of Peer Support Services

The behavioral health workforce has suffered attrition over the last decade and peer specialists have filled in some of the staffing gaps. Peers have provided interventions that have resulted in measurable improvements in client's personal and functional activities that are essential for health, safety, and continued wellbeing.

According to the Center for Medicaid and Medicare Services, "peer support is an evidence-based model of care that consists of a competent and qualified peer support provider who assists individuals with their recovery" (see https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf).

The Substance Abuse and Mental Health Services Administration determined that peer support workers are people with success in their recovery process and who can assist others that experience related situations. Peers help others to engage in recovery, and peers lessen the likelihood of relapse. They are effective in extending the reach of treatment outside clinical settings into the day-to-day environments of those seeking or in recovery. (see www.samhsa.gov/brss-tacs/recovery-support-tools/peers)

With peer support having such extensive potential for recovery and rehabilitative utility and efficacy, SAMHSA has called peer support the future of behavioral health (see https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/peer-support-recovery-future). In articles published in 2016 and 2019, others have echoed SAMHSA by calling peers the future of mental health (see *Epidemiology and Psychiatric Sciences* @ https://pubmed.ncbi.nlm.nih.gov/26744309) and *Forbes* (see https://www.forbes.com/sites/denisebrodey/2019/03/26/the-future-of-mental-health-care-change-is-already-here)

Peers Working to Assist Those Transitioning from Incarceration

The Nehemiah Project (TNP) is in the second year of a contract with the federal agency in charge of D.C. citizens that are incarcerated across the country in the federal system. TNP operates several recovery homes in D.C., Maryland, and Virginia for formerly incarcerated men with co-occurring disorders that interrupt their activities of daily living (ADLs). Many of these disorders often go undiagnosed and untreated. Upon release, the formerly incarcerated men or returning citizens reside in the TNP residences from 1 to 180 days. Specifically, TNP targets the

ADLs that involve maintaining independent living, finding and keeping gainful employment, compliance with legal obligations, and healthy community re-integration.

One of the unique features about this work is that the majority of the public pool of applicants that are attracted and interested in TNP's mission and vision are those that have personally recovered and rehabilitated from previous justice-involvement along with their own behavioral health and physical conditions. TNP specifically employs returning citizens that either have fully recovered and rehabilitated or are actively engaged in their recovery and rehabilitation.

During the pandemic, TNP lost several professional staff members with graduate degrees that were essential to the routine operations of the houses. Attempts to replace the outgoing staff proved difficult since new staff would have to work in close proximity with residents - many of whom were recovering from COVID-19, while managing addictions, mental illnesses, and other physical conditions. Also, working in recovery houses isn't seen as very attractive or lucrative. It's hard, often thankless work that will often leave you frustrated and fatigued - wondering if you are making a difference.

With the attrition of professional staff, TNP continued to operate with a cadre of non-professional housing monitors. When TNP could not replace the outgoing professional staff, TNP reimagined and recalibrated our provision of services. After having consulted the evidence-based research and strategies of successful recovery facilities, TNP decided to give the housing monitors formal training in peer support. TNP investigated several area providers of peer recovery training and during that process, TNP determined that Jordan Peer Recovery was the best provider to help TNP accomplish its training goals.

Jordan Peer Recovery (JPR) has a demonstrated track record of success across the country in training peers and providing continuing education and support for trained peers to become certified by state and national authorities. JPR's connection to Bowie State University and utilization of subject matter experts that are also known and respected community leaders made them stand out. Moreover, JPR's model for instruction and subsequent support was cutting-edge. JPR's model was convenient, affordable, engaging, local and fun. In TNP's investigation, no other peer training entity in the region had the experience to assist us in providing the training that would provide our staff with the competence and qualification to satisfy our federal funders. So, TNP's housing monitors actively participated and completed the JPR peer support training. Fifteen housing monitors successfully completed the peer training and became state certified. Five of the certified peers then received the integrated forensic peer specialty training and went on to be state certified as forensic peer specialists. The recovery homes are now staffed by resident monitors that are also peer and forensic peer specialists trained by Jordan Peer Recovery.

There are several social issues that returning citizens face that impact and influence their community re-integration. Among the community disenfranchisement and additional restrictions in place as a result of justice-involvement, returning citizens experienced and expressed the presence of a range of other barriers and social determinants that directly impacted their abilities to engage their ADLs - particularly, finding gainful employment and

appropriate housing. The adversarial and punitive nature of the prosecution and parole stages of the justice system has taught convicted and formerly incarcerated people not to express difficulties or deficits in functioning for fear that such admissions could have a negative, collateral impact on their liberty interests in some way. Consequently, the returning citizens in TNP housing rarely admitted to professional staff that they needed assistance even when they failed to produce timely outcomes demonstrating improvement in ADLs, such as progress toward locating housing and employment.

In SAMHSA's publication *Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide* (see https://store.samhsa.gov/sites/default/files/d7/priv/sma19-5097.pdf), the authors found that appropriate housing and gainful employment were among the other salient necessities that increased the chances of preventing recidivism among justice-involved populations.

TNP also found that housing and employment are considered health interventions, which further bolstered our vision, mission, and the importance of our work (see *Employment is a critical mental health intervention* published by Epidemiology and Psychiatric Sciences @ https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7681163/pdf/S2045796020000906a.pdf and *Housing as Health* published by the American Medical Association @ https://jamanetwork.com/journals/jama/fullarticle/2667710)

Because TNP staff certified peer specialists have successfully negotiated their own justice-involvement, health issues, and housing and employment challenges, they were uniquely trained to help our residents overcome their stigmas and barriers. The JPR training made TNP staff competent in targeting the client factors, relationship factors, craft techniques, and expectancy factors that the evidence-based research says works in all helping relationships.

Criminal justice research shows that returning citizens often have 9 months from release to recidivism. TNP residents have up to 6 months in our transitional housing - therapeutic community setting. The experiences and expressions of the returning citizens in TNP housing demonstrate that incarceration had deleterious effects on the total functioning of the residents. Every single resident had difficulty of some sort making repeated, uninterrupted strides toward improving their ADLs and achieving community reintegration. Among all of the social determinants of health and well-being, appropriate, affordable housing and gainful employment have the highest predictive potential of recidivism reduction. TNP had a short window to target, diagnose, engage, and support our residents regarding achieving ADL improvements. The residents are quite vocal about social, community, and environmental barriers that effect them. They are less candid and open about issues that are impacting them personally that get in the way, such as undiagnosed and untreated trauma, intellectual dysfunction, neurocognitive issues, developmental and behavioral issues, and the myriad of mental and emotional challenges. These issues have a substantial impact on their abilities to locate and maintain employment and housing. The inability to negotiate these challenges and barriers invariably lead back to criminal schemas and recidivism. Identifying these issues are important to make progress toward improving ADL functioning as well as mitigating some of

the judicial penalties and restrictions that the residents face when they don't make the expected measurable progress.

We detected a pattern wherein the residents learned to say the "right" things to our professional clinicians even though their actions were not demonstrating commensurate outcomes. However, our JPR-trained staff peers were overwhelmingly successful in spotting cues and signs of internal dysfunction that appears to be unique to justice-involved populations. Certain language and behavior patterns were obvious to peers - even when they were less observable to others. Peers were not afraid to call-out the cues and behaviors and through their relationships, address cognitive dissonance and distortions as well as model behaviors that measurably addressed stuck points and initiated requests for higher forms of care for the more acute issues.

Enlisting the peers and incorporating their training and experiences in how we served our residents resulted in an expanded, interdisciplinary model wherein the peers became the first responders and the professional staff and management became the peers' consultants. Noting that the staff peers were exhibiting traditionally "clinical skills" of client assessment, and with the intention of expanding their skill set, TNP sought to empower peers to administer measurement tools around ADLs. The peers could then consult with clinical staff around residents with higher level needs. Besides professional development for the peers, we also felt that residents would be more likely to give accurate responses to peers based on their shared lived experience and sense of trust. Our federal funders were also on board, as they had noted that in TNP's transition from professional clinical staff to more peer driven work, our success rate for resident treatment completion rose from 48% to 52%, and this without the significant training in peer support services which we later implemented.

Study Objective

To help assess TNP's ongoing professional development of peer staff within TNP's program model, the study posed the following research question:

1. To what extent are peer specialists at a residential transitional re-entry housing program able to contribute to assessing residents in greater need of support through the administration of a validated ADL measure?

Methods

Sample

During this study, TNP serviced 212 men, ranging from 18 to 73 years old. There were 47 men who had been convicted of sex offenses, 19 had been convicted of murder, and 35 had been convicted of burglary and other forms of robbery, theft, and fraud. There were 22 who had been convicted of weapons and different forms of assault and low-level violence. There were 89 who had been convicted of various drug offenses, including possession and distribution of opioids. This represented a combined 3852 years of sentenced time of incarceration.

There were 97 who had high school diplomas and 12 had college degrees. 104 did not have education beyond 8th grade. In fact, 37 did not have education beyond 6th grade. One was a former police officer and 13 were former military. One was a former teacher, one was a former nurse, and one was a former doctor. Two were former construction workers and nine were former college students. All 212 had at least 4 or more adverse childhood traumatic experiences at intake. There were 31 who had borderline personality disorders, and 77 had antisocial personality disorders. There were 24 who had forms of schizophrenia, and 59 had anxiety and depression conditions. Over half, or 123, had substance use disorders. Regarding physical health conditions, nine had one or more forms of cancer, MS, COPD, and/or HIV at intake. There were 81 on different forms of pain and medication management for all kinds of conditions. Regarding social determinants of health, 208 were unemployed and living in places that they did not own or share the expenses of upkeep at the time of conviction. A great majority, 193, admitted to adherence to forms of spirituality and religious expressions at intake. 24 were devout while in the TNP program and indicated that their faith was an essential element of their recovery and rehabilitation.

Our 15 TNP staff peers have similarly situated past criminal involvement. Our peer staff range from 32 to 66 years old. Five have recovered and rehabilitated from burglary, robbery, fraud, and other kinds of theft. One recovered and rehabilitated from a sex offense. Three recovered and rehabilitated from murder. Three recovered and rehabilitated from weapons convictions and forms of assault and low-level violence. Four recovered and rehabilitated from various drug offenses, including possession and distribution of opioids. They represent a combined 303 years of sentenced time of incarceration.

All TNP staff peers have graduated high school or have GEDs. Four are degreed through college education. Twelve have physical and mental conditions that are being satisfactorily managed. Two are in long-term recovery from substance use disorders. Two were former military, one worked in construction, and one was an addiction counselor. All 15 were unemployed and living in places that they did not own or share the expenses of upkeep at the time of conviction. All 15 indicated that their faith, spirituality, and religious traditions were essential to their recovery and rehabilitation. All 15 stated that they are still adherents. All are gainfully employed, and all are appropriately and independently housed.

Study Procedures and Measures

The returning citizens that made up the sample were assigned to the Nehemiah Project by the federal agency (Court Services and Offender Supervision Agency) for 180-day minimum stay. The returning citizens then are assessed and provided with wrap-around services to assist them with employment and long-term housing. The JPR trained peer-monitors were tasked with the day-to-day managing of the residents' schedules and progress while in the program.

Returning citizens were scored on a modified ADL checklist (see https://www.ncbi.nlm.nih.gov/books/NBK470404). Our checklist measures whether a resident functions independently, requires assistance, is dependent on caregivers, or doesn't do the

particular function at all on 20 scales. While we also asked for Global Assessment of Functioning and WHODAS scores, we did not include those as part of our analyses for this study.

In preparation for their administration of the ADLs checklist, peers were given the standard 4-hour training on how to conduct the interview. The staff peer monitor would first spend some time getting to know a resident and building a rapport. Then, the peer monitor would use motivational interviewing techniques to ask the resident about his level of functioning on each of the 20 scales. Each of the ADL checklists were then compared with the resident's historical data given by the paroling authorities along with the real-time employment and housing assessments given by TNP professional specialists.

To measure staff peers' ability to implement the ADL measurement tool, TNP used document analysis. We examined the 212 ADL checklists for completeness: client name, provider name, date, checklist done in ink, and one clearly marked box for each of the 20 scales. The researcher, who serves as a TNP associate director, also conducted 52 initial direct observations to further assess whether peers were conducting the interviews and completing the forms with the residents according to the training.

Results

Of the 212 ADL checklists administered by staff peers, 44 (21%) were incomplete initially in that they either did not have the resident's full name, dates, or the peer's name on the documents. Seven of the 44 appeared to have more than one box checked and could not be immediately determined from one glance.

From the 52 initial direct observations, 19 interviews being conducted by 3 peers had to be stopped because the peers gave inappropriate explanations of "transferring" and "managing medications." The interviews were successfully completed with the residents by different peers on subsequent days. With a third of the monitors and interviews being in error, I provided a 1-hour refresher to all 15 peers. In that refresher training, I gave specific definitions for each scale. I also administered a 20- question exam with no prompts - asking for the appropriate definitions of each scale. The same 3 monitors had difficulty remembering the definitions. I then required all of the monitors to read the prepared definitions for each scale to the residents in each interview. I conducted 25 follow-up direct observations and did not find any errors in the interview or the completeness of the checklists.

Discussion

Study results appear to coalesce with the current knowledge base. The peer profession does not have any formal assessments and inventories that are unique to the craft. In general, only a fraction of all psychometrics can be administered and interpreted by non-clinical professionals. This study demonstrated that with the appropriate training and supervision, peers can properly administer and interpret the ADL checklist as part of the continuum of services they currently provide.

Study Implications

Evidence-based best practices require that an assessment be performed before services can be provided. Some measurement of a service recipient's present functioning is necessary to prepare a delivery trajectory for any interventions. In many settings, peers rely on and take cues from the other professionals in their agencies to conduct and interpret the measurements of present functioning. Peers are capable of expanding their acumen and skill repertoire to administer and interpret measures (such as the ADL checklist) that are aligned within their competencies even though the measures themselves may lie outside of the regimen previously contemplated for peer practice.

Not all measurements used by professional clinicians have immediate utility in competent peer practice. More research is needed to distinguish which psychometrics can be administered and interpreted by qualified and competent peers with the appropriate training and supervision. Even measurements within public domain without official use criterion that are used across different public health settings may need scrutiny to ascertain whether the measure could be ethically used in peer settings.

Study Strengths and Limitations

This research had some notable strengths and limitations. The study showcased the effectiveness of peer practitioners that can appropriately assess a service recipient's needs in order to craft interventions to deliver the requested outcomes. One caveat worth mentioning involves the host of other assessments of measurements that may have potential utility that could not be covered in this study. There may be other metrics out there that peers can competently use, and more study is necessary to create a menu of measurements that could advance peer practice and can be embraced by peers in different settings. Also, the study results from TNP may not be generalizable to other settings serving different clientele, with different peer staffing, and with different management and organizational structures. More research is needed to assess whether similar results would be found.

Conclusion

The efficacy of peer support services is well established. In order to provide services, peers must first conduct an assessment to determine a service recipient's need. Then, the peer professional must tailor the proposed interventions to their needs. Justice involved populations benefit from peer specialists that share similar experiences. When properly trained and supervised peers utilize the ADL checklist with justice involved populations, the results of the measurement highlighted several functions of interest that could become the focus of appropriate peer services, such as housing and employment. These 2 ADLs are critical to reduce recidivism for returning citizens within the most acute post-release time frame (within 9 months). If affordable housing and gainful employment is maintained by returning citizens, reduction of recidivism is sustained past the critical two- to five-year period. This study shows that staff peers are capable of administering the instrument, though advance training, observation, coaching, and ongoing education are important to ensure proper implementation.