

ACT Peer Support Specialist Training

Evaluation Report

March 26, 2008



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How Many Participated

Fifty-nine (59) participants in three cohorts of training for ACT Peer Support Specialist (PSS) were surveyed on the last day of their training on a number of outcomes variables, including current employment status. At six months post-training, 43 participants responded to a second measurement. At twelve months post training, 23 of the original 59 participants provided a third survey measurement.

How the Study Was Done

Participants were asked to rank their motivations for seeking employment as a peer support specialist. The measurement of motivations for training included: *Making friends, Making money, Changing attitudes, Gaining acceptance, Helping consumers with recovery, Earning respect, and Helping professionals see the consumer's point of view.* Ranking occurred on a 5-point Likert scale ranging from "Not at all true" to "Extremely True." The scale also included an option of "Don't know/Not applicable." At six months and twelve months post training, participants were asked to rank their experience in terms of Making friends, Making money, etc.

Participants also were asked about perceptions about their quality of life and empowerment on the last day of their Peer Support Training, and again at six and twelve months post training. Measurement of quality of life involved completion of the 12-item Quality of Life scale and the 28-item Empowerment scale from the Ohio Outcomes System. The Quality of Life scale contains a 4-item Social Connectedness subscale that also was analyzed. The Social Connectedness construct did not prove to be a significant variable in the study sample.

At six months post training, participants also were asked whether they had applied for positions as a peer support specialist (PSS), obtained a position as a PSS, and whether they had found employment with a mental health provider in some other capacity. Participants were asked the same questions at one year post training.

At all three times, participants were asked whether they had worked full- or part-time in the previous six-month period. Participants also were surveyed for racial and ethnic identity and years of education.

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Description of Participants

Eighty-six percent (86%) of the original 59 participants self-identified as White, and 14% of the sample identified as African-American. While this distribution is representative of the state's general population, it under-represents the distribution of African-Americans in the population of consumers served in the public mental health system. In 2007, 23% of consumers served by ODMH self-identified as African-American. There were 22 men and 37 women in the original cohort of 59.

The 59 participants reported an average of 13.95 years of education, ranging from 11 to 18 years, with a standard deviation of 1.6 years. The median length of education for the group is 13.40 years, and the mode is 13 years.

At the time of training, 36 participants (61%) reported either full- or part-time competitive employment. Fourteen (14) participants reported full-time, and 22 reported part-time employment. At the time of training, four participants were already employed as peer support specialists (PSS). Employment in either a full- or part-time job varied over the three time points, as shown in Table 1 below:

Table 1.
Employment Status at Three Times

Employment Status	Time 1	Time 2	Time 3
Number Full-Time	14	7	6
Number Part-Time	22	16	9
Percent of Sample	61%	53%	65%

Results Six Months After Training

At six months post training, 53% (N = 23) of the 43 participants in the sample reported either full- or part-time employment. Five (N = 5) of the 43 respondents reported applying for a position as a peer support specialist. Of those five, one was newly hired into a PSS position within six months of training. Three participants indicated at the Time 2 measurement that they were employed as Peer Support Specialists at the time of training.

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At six months post-training, five participants reported employment as peer support specialists, and another 12 reported either full- or part-time employment with a mental health provider in a position other than that of a peer support specialist. Position titles included facilitator, coordinator, educator, outreach worker, and advocate. Thus, 17 participants reported employment with a mental health provider at Time 2. At the same time, 17 participants reported no employment, and 9 participants reported either full- or part-time employment in a job outside of mental health.

Between Time 1 and Time 2, 43 participants showed a significant change in their mean ranking on motivations for training to work as Peer Support Specialists versus their perceptions of post-training work experience on three items: *Making friends*, *Helping others along the road to recovery*, and *Helping professionals understand the consumer's point of view*. There was no difference between participants on the basis of employment or place of employment. A one-tailed Wilcoxon Signed Ranks Test returned the following results at $a < .05$:

Table 2.
Critical Wilcoxon T Values for N = 43 Signed Ranks

Item	T	T1 Mean	T2 Mean	Sig.
<i>Making Friends</i>	-.989	2.43	3.19	.029
<i>Helping others with recovery</i>	3.299	3.93	3.37	.0001
<i>Helping professionals understand consumers' point of view</i>	3.099	3.83	3.14	.0034

With $T = -.989$ for “Making friends at work,” respondents indicated a higher number of positive rankings of the item at Time 2 than Time 1 (See Table 2, above). The other two items, however, indicate a higher number of negative rankings by respondents at Time 2 than Time 1.

Empowerment and Quality of Life

Mean scores for the 43 participants on the Empowerment scale were 3.13 at Time 1 and 1.87 at Time 2, indicating that participants experienced a substantial drop in their perceptions of their own empowerment. A paired sample T-Test of the T1 and T2 Empowerment scale mean scores

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indicated a significant difference at $a < .001$, with $T = 12.026$. There was no difference between participants based on employment status or employer.

Mean scores for the 43 participants on the Quality of Life scale were 3.44 at Time 1 and 3.46 at Time 2. No statistically significant difference was found in these scores.

Results Twelve Months After Training

At 12 months post-training, 65% (N = 15) of the 23 participants in the sample reported either full- or part-time employment. Two (N = 2) of the 23 participants reported applying for positions and obtaining employment as a Peer Support Specialist in the preceding six-month period. At the end of 12 months, six participants reported employment as PSS: three participants indicated their employment occurred after the training took place and three participants said they were employed as PSS at the time of training.

At 12 months post training, six participants reported employment as peer support specialists, and another seven reported either full- or part-time employment with a mental health provider in a position other than that of a peer support specialist. Thus, 13 participants reported employment with a mental health provider. At 12 months post training, six participants reported no employment, and four participants reported either full- or part-time employment in a job outside of mental health. (See Table 3 below.)

Table 3.
Type of Employment of N = 23 Participants at T3

Employment Status	Number
Peer Support Specialist	6
Other MH Employment	7
Employment outside MH	4
Unemployed	6

Two groupings within the four categories of employment status held statistical significance in subsequent analyses of variance using a repeated measures test (MANOVA) on Empowerment and Quality of Life scores. (See Tables 7 and 8.) The two groups associated with statistical

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significance are Peer Support Specialist (N = 6) and all other categories (N = 17) and Mental Health Employment (N =13) and all other categories (N = 20).

Motivations for training and post-training experience

Between Time 1 and 3, participants showed a significant change in the difference between motivations for training and post-training experience on three items: *Changing attitudes toward mental illness, Helping others with recovery, and Helping professionals understand the consumer's point of view* (See Table 4 below). There was no difference between participants on the basis of employment or place of employment. A one-tailed Wilcoxon Signed Ranks Test returned the following results at significance of $a < .05$:

Table 4.
Critical Wilcoxon T Values for N = 23 Signed Ranks

Item	T	T1 Mean	T3 Mean	Sig.
<i>Changing attitudes toward mental illness</i>	4.773	3.36	2.00	.000
<i>Helping others with recovery</i>	2.799	3.81	3.17	.002
<i>Helping professionals understand consumers' point of view</i>	2.912	3.68	2.87	.007

As shown in Table 4 (above), all three items indicate a higher number of negative rankings at Time 3 compared to Time 1.

Empowerment and Quality of Life:

Paired Samples T-Tests

A paired samples T-test was done on Empowerment and Quality of Life scores at all three time periods. With the Empowerment scale, there was significant decline in mean scores from Time 1 to Time 2 and Time 3, but no significance in the decline from Time 2 to Time 3. Given the administration of the scale at the closure of the training when participants presumably felt encouraged and affirmed by the week's activities, the drop in scores between Time 1 to Time 2 was expected.

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Table 5.
Paired Samples T-Test for N = 23
On Empowerment Scale

Time Pairs	T	T1 Mean	T2 Mean	T3 Mean	Sig.
T1 – T2	8.996	3.15	1.87		.000
T1 – T3	9.586	3.15		1.79	.000
T2 – T3	1.133		1.87	1.79	.270

On the Quality of Life scale, there was an increase in mean scores over the three time periods. This increase in mean scores approached significance at $\alpha < .05$ between Time 1 and Time 3, and reached significance between Time 2 and Time 3. (See Table 6 below.)

Table 6.
Paired Samples T-Test for N = 23
On Quality of Life Scale

Time Pairs	T	T1 Mean	T2 Mean	T3 Mean	Sig.
T1 – T2	-.118	3.42	3.43		.907
T1 – T3	-1.873	3.42		3.65	.074
T2 – T3	-2.127		3.43	3.65	.045

Repeated Measures Tests

A repeated measures test (MANOVA) was run to determine whether employment status would differentiate the change in mean scores for Empowerment over time. The Mental Health Employment/All Others grouping was not a significant predictor of variance, but the Peer Support Specialist/All Others grouping did prove to be significant. (See Table 7 below.)

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Table 7.
Repeated Measures Test for N = 23
On Empowerment Scale

Measures	N	T1 Mean	T2 Mean	T3 Mean	F	Sig.
PSS	6	3.20	1.89	2.02	4.956	.037
Other*	17	3.13	1.86	1.70		

A MANOVA on the Quality of Life scale detected a difference at a significance of $a = .06$ between the 13 participants employed by mental health providers and the 10 who were unemployed or employed outside mental health. (No difference was found on the Quality of Life scale for the PSS/Other grouping.) In Table 8 below, the mean score on Quality of Life of participants employed by mental health providers is shown to be significantly lower than the mean score of those who were either unemployed or employed outside mental health. The six participants who were unemployed and the four employed outside mental health consistently reported higher rankings across time on Quality of Life than the individuals employed by mental health providers.

Table 8.
Repeated Measures Tests for N = 23
On Quality of Life * Employment

Measures	N	T1 Mean	T2 Mean	T3 Mean	F	Sig.
Employed by MH provider	13	3.20	3.27	3.51	3.861	.063
Other*	10	3.71	3.65	3.83		

*Unemployed = 6; Employment other than MH provider = 4.

Exploratory analysis of individual items in the Quality of Life scale provided two possible clues about this finding: Participants employed by MH providers were no less or more satisfied than all others in the sample on three Quality of Life items regarding money, financial security, and discretionary income. Participants employed by MH providers were significantly *less* satisfied than all others in the sample on the Quality of Life item regarding personal safety.

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Discussion

Given the small sample size and lack of randomization, study findings cannot be generalized beyond the sample. The data collection for the PSS Training evaluation did not capture all the information about trainees' employment as Peer Support Specialists, because the question about employment at Time 1 did not ask about type of employment. Although questions at Time 2 and Time 3 did ask about type of employment, the sample size decreased by 27% at Time 2 and by 61% at Time 3. Thus, the study probably underestimates how many of the original 59 trainees were already employed as Peer Support Specialists. Because of the decreased sample size, the study may also underestimate how many of the Time 1 trainees were employed as Peer Support Specialists at Time 2 and Time 3.

Despite the study's limitations, the finding of differences between motivations for training as a peer support specialist versus post-training experience at six and twelve months is interesting. In particular, it is worth noting the consistent decline across three time measurements in participant ranking on the items *Helping others with recovery* and *Helping professionals understand consumer perspectives*. This suggests that over time, trainees may have perceived a certain amount of intransigence on both sides of the therapeutic relationship. Participants appear to have felt increasingly discouraged over an inability to make a positive impact on consumer attitudes toward recovery or professional attitudes toward consumer perspectives.

The survey was administered on the last day of the PSS training when participants' perceptions of empowerment might understandably be higher than usual. Indeed, there was an expected decline in mean scores on the Empowerment scale from Time 1 to Time 2. The decline in the means from Time 2 to Time 3 was not nearly as dramatic or statistically significant, suggesting that the Times 2 and 3 scores are closer to the sample's true baseline on the Empowerment scale than the mean score at the conclusion of training. It would appear that perceptions of empowerment were positively influenced by the PSS training, but the training did not associate with sustaining an elevated perception of empowerment over time.

It is noteworthy that the six individuals employed as Peer Support Specialists reported significantly higher mean scores than all others on Empowerment over time. This finding may

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have been influenced by four participants in the group of six Peer Support Specialists who were already employed in these positions the time of their training. It also raises a question about those who were not employed as Peer Support Specialists: Is there a lowered perception of empowerment over time among people who are trained for a job for which there exists little or no employment opportunity? The number of individuals who applied for positions and were not hired at Times 2 and 3 is not large enough to support a statistical comparison of mean scores on Empowerment.

The Time 3 sample of 23 participants showed significant *increases* in the group means for Quality of Life across the three time periods. Although participants employed by Mental Health Providers (MHP) and all others (See Table 8) each reported an increased mean score on their Quality of Life perceptions over time, the lower scores of participants in the MHP group begins to approach significance at $a = .06$. In this analysis, field of employment suggests a possible influence on the participants' Quality of Life assessments. Preliminary analysis also suggests that a diminished perception of personal safety is an issue for participants employed by mental health providers. More research with the Ohio Outcomes System's 12-item Quality of Life scale is needed to determine whether differences hold up on a larger sample with regard to quality of life perceptions and type of employment. However, if a diminished perception of personal safety is a valid finding for mental health employees, it should be addressed when training vulnerable people to work in the field with their peers.