Peer Advocate Program at LACDMH

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Introduction

The unique contributions of peer advocates within clinical settings are increasingly being recognized as valuable components of recovery-oriented care. Central to the transformation of the mental health system is the understanding that consumers are not passive recipients of treatment but are key players in the design and delivery of services. Peer advocates help to normalize and destigmatize the client experience and model ways of thriving in the community while coping with a mental illness.

Since the early 1990s, the emerging recovery movement has facilitated the widespread utilization of peer support in the mental health workforce across the United States and has brought with it an increasing expectation of consumer involvement in all aspects of care. From a recovery perspective, peer advocates help to instill hope and to empower clients with the self-determination needed to integrate with their communities. Equipped with their first-hand experience with the mental health system, peer advocates possess the empathy and unique insights needed to help clients navigate an otherwise intimidating and overwhelming system.

Existing research indicates that peer advocate services provided within mental health agencies can be as effective, or more effective, than standalone traditional services. When consumers receive treatment enhanced with peer advocates, they have fewer hospitalizations, reduce their substance abuse, use fewer crisis services, have improved employment outcomes and have better social functioning and quality of life when compared to those who do not receive consumer-based treatment (Armstrong et al., 1995; Besio & Mahler, 1993; Klein, Cnaan & Whitecraft, 1998; Felton et al., 1995). However, despite these positive outcomes, there is evidence to suggest that many agencies have struggled to successfully implement peer-support programs and even, in some cases, created hostile and discriminatory working environments for peers (Carlson, Rapp, & McDiarmid, 2001; Dixon, Krauss, & Lehman 1994; Manning & Suire, 1996; Mowbray et al., 1996; Vandergang, 1996).

This report seeks to assess the peer-advocacy program at the Los Angeles County Department of Mental Health (LACDMH). It includes the findings from two clinic sites, as identified by the Deputy Director of Adult Systems of Care, and consists of twelve interviews, inclusive of 3 supervisors, 1 clinic director, 4 peers, and 4 clinic staff who worked closely with the peer-advocates. Interviews were conducted between March, 2011, and February, 2012, by researchers Eri Nakagami and Jorge Avila (for Spanish-speaking participants).

Methods

The study was approved by the UCLA Institutional Review Board and all data collected was de-identified prior to analysis. We assessed peer employee programs in two clinic sites to recruit the sample for the study. After providing consent to be approached by the research staff, one of the authors (EN) contacted the potential study participants to discuss and review the project protocol as well as review the informed consent with the participant to ensure that individuals, including those with limited reading and/or cognitive-attention skills, fully understood their rights and any potential risks before agreeing to participate. After they agreed to participate in the study, consent was obtained in accordance with the UCLA IRB-approved guidelines to participate in the study.

Initially, we planned to sample all Peer Advocates and Peer Community Workers employed at two clinics identified by the Deputy Director, ASOC, along with the peers' direct supervisors. We completed interviews at one of the identified clinics (Clinic A), but could not obtain a sufficient sample of consenting participants at the other site. We then contacted several other clinics that had active peer employment programs and elected to conduct interviews at Clinic B, where we were able to identify a sizable sample of consenting participants.

The study used a mixed-methods design characterized by the collection and analysis of qualitative and quantitative measures. This design was chosen to complement and enrich the results obtained by both methods, thereby increasing understanding and knowledge of the integration of peers within clinic culture, their relationship with staff and other consumers, as well as the impact of the peer job on the peer, staff, other consumers, and the clinic.

Semi-Structured Interviews

Prior to the study, we developed a semi-structured interview guide (see Appendix A for the interview guide questions). The interview guide ensures efficient, focused, and systematic use of limited interview time. The interviews were free-flowing conversations during which explored (1) the daily activity of peers in the clinic, (2) the effective aspects and areas of improvement of the peer employee program, (3) how the peers are integrated into the clinic, and (4) the impact of the peer job on the peer, the staff, the clinic, and other consumers.

Qualitative research is "a continual reflexive process" (Nastasi & Schensul, 2005, p. 183; Wertz, Charmaz, et al, 2011) between theoretical deductive logic and empirical inductive reasoning. Each interview was assigned a number for identification, transcribed by a confidential transcriber, and reviewed by the interviewer for accuracy. The interviews were then comparatively analyzed in Dedoose, a UCLA-developed qualitative data analysis web application, for thematic content, using the questions outlined above as a framework and employing a grounded theory approach. Each theme identified was queried against the remaining interviews in the database, using a constant comparative method, and subthemes were combined under more generalized thematic headings.

Self-Report Measures

In addition to the semi-structured interview, we administered four validated self-report measures to assess internal and external stigma in both peers and their supervisors. The measures are more fully described in Appendix B. Clinic Directors and supervisors completed the Attribution Questionnaire and Beliefs about Mental Illness Scale. Peer workers completed the Recovery Assessment Scale and Stigma Scale.

Data Analysis and Results

The data sample consisted of eight peers and seven supervisors. Of the eight peers, three were males and five were females, while of the seven supervisors, three were males and four were females. The small sample size precluded a meaningful comparison of the groups by clinic sites. We therefore conducted a descriptive analysis for each measure, including the factors for some of the measures. The data are presented in Table 1.

Table 1 **Scores on Self-Report Measures**

		Supervisors	Consumers
Gender	Male	3	3
	Female	4	5
Total		7	8
		Supervisors	
Attribution Questionnaire			
Blame		10 (3.87)	
Anger		5 (1.15)	
Pity		15 (5.35)	
Help		22.43 (5.38)	
Dangerousness		6.57 (3.46)	
Fear		6 (3.27)	
Avoidance		10.71 (4.64)	
Segregation		4.71 (2.29)	
Coercion		7 (3.46)	
		Supervisors	

Beliefs about Mental Illness		
Total	147.14 (10.37)	
		Consumers
Recovery Assessment Scale		
Personal Confidence and Hope		37.38 (3.66)
Willingness to Ask for Help		13.75 (1.91)
Goal and Success Orientation		22.88 (1.81)
Reliance on Others		15.99 (1.64)
Not Dominated by Symptoms		12.63 (1.77)
Stigma Scale		
Discrimination		22.86 (6.73)
Disclosure		15.5 (8.54)
Positive Aspects		6 (2.83)
Total		44.38 (12.66)

Supervisors: On the Attribution Questionnaire, the supervisors showed relatively positive attitudes toward ‘‘Harry,’’ the hypothetical peer who works as a clerk in a law firm and has been hospitalized for schizophrenia. The supervisors in this sample attributed no blame to “Harry,” and expressed no feelings of anger or fear toward him. Although the respondents felt strongly about not segregating “Harry,” they did have slight feelings of avoidance (mean score 10.71 of a possible 27), indicating some residual stigma. The supervisors also felt some pity towards “Harry” (mean score 15 of 27) and a strong desire to help him (mean score 22.43 of 27). On balance, however, the supervisors in the present small study sample showed positive attitudes toward recovering peers. The scores on the Beliefs about Mental Illness Scale (mean 147.l4 of a possible 175) were relatively high, indicating that this group of supervisors are knowledgeable and had positive attitudes about mental illness.

Peers: As a whole, the peers in this sample scored highly on the Recovery Assessment Scale. They reported high levels of personal confidence and hope (mean score 37.38 out of a possible score of 45), as well as strong orientations towards goal achievement and success (mean 22.88 out of 25). They described themselves as very willing to ask for help (mean 13.75 out of 15) and as generally willing to rely on others (mean 15.99 out of 20). Finally, the peers expressed confidence that their symptoms would not interfere with their work or lives (mean 12.63 “symptom non-dominance” score out of a possible score of 15).

However, the peers also reported experiencing a certain level of continuing stigma. Overall, they scored lower on the total and on all three sub-scales of the Stigma Scale than the means reported by the measurement development sample (see Table 2 below). The scores indicate that these peers felt they were somewhat discriminated against and had experienced negative reactions from other people, including acts of discrimination by health professionals and their clinic employers, as well as from others in the community, such as the police. Despite these perceptions, the peer workers reported relatively little reluctance to disclose their mental illness and they were relatively open to accepting their illness and to experiencing positive changes as a result of their illness.

Table 2: Peer Worker Scores on Stigma Scale

Factor	**Possible Score**	**Mean Score of Development Sample**	**Mean Score of This Study Sample**
Discrimination	50	29.1	22.86
Disclosure	50	24.7	15.5
Positive Aspects	40	8.8	6
TOTAL	140	62.6	44.38

Results of Qualitative Analysis

Overall Program Assessment

The peer advocate program shows many signs of promise and success in LA County. Peers, supervisors, and peer coworkers demonstrate a strong understanding of the program's significance and its contributions to their agency. It is described as "revolutionary", "exciting", and "a blessing". Although it is not without its "complications," all staff interviewed gave a generally positive assessment of the peer advocate program as they have experienced it.

Consumer workers experience the program as "rewarding" and enjoy the benefits associated with having a job. One consumer explained, "I'm able to work and be happy and be productive, and my quality of life improved." However, the experience is not just viewed as a job, but also as an opportunity to use their lived experience to enhance service delivery. Recognizing the significance of integration, peers value the opportunity to "give back" using "a whole different perspective".

Supervisors also value the integration of peer advocates in the clinic. One supervisor stated, "I've worked for this clinic now, I think twelve years, so I've seen a lot of the changes that happen, and I would say that that's one of the better changes that the county has made..." Because of the personal lived experience consumers bring to the agency, their contributions serve as a "vital function" to enhance service-delivery. Another clinic supervisor noted that client no-show rates had improved due to the integration of peer advocates, a change that s/he attributed to the "hope" and the "unique information" that they bring to their clients.

Non-consumer coworkers also appreciate the contributions made by peer advocates. One individual reported, "I think the whole peer advocate thing is an amazing adventure. I mean, I think it's great. They aren't very hard to work with." Although respondents described some challenges, their overall assessment of the program is positive.

The study identified three types of major challenges faced by peer workers: workload disparity, lack of career path, and stigma.

What do Peer Advocates do?

Peer Advocates are engaged in a wide variety of activities, which vary from peer to peer. Responsibilities include, but are not limited to:

- Calling clients to remind them of their appointments, rescheduling if necessary
- Conducting follow-up phone calls
- Helping clients complete research surveys
- Assisting with prescription refills
- Greeting and giving information and support to clients in the waiting room
- Assisting clients with paperwork (e.g. Medi-Cal applications)
- Co-facilitating groups which may include Arts & Crafts, Manual Arts & Self Esteem, Life Beyond Mental Illness, Smoking Cessations, Anger Management, Road to Recovery, Co-Occurring Disorders, Creative Writing, Photography, Family Support Group, Employment and Education, Journaling
- Referral and linkage
- Attending and assisting client outings
- Assisting with new client orientation
- Guest-speaking at events
- Conducting individual case-management
- Picking up or dropping off clients using the county car
- Translating for other staff

Challenges: Workload Disparity

Workload disparity was one of the challenges most frequently discussed by supervisors, peer advocates, and coworkers. The reasons for this include differences in advocate health; lack of clear program guidelines and expectations; and differences in skill level. Responsibilities are highly contingent upon the health and cognitive functioning of the peer advocate. Whereas a low-functioning peer advocate, who may be "more sick than some of [the] clients", can have no actual responsibilities and is only able to “shadow” peer colleagues, a high-functioning peer advocate, on the other hand, may work on the level of a “junior social worker”.

While differences in cognitive functioning and inherent skill level partly explain responsibility discrepancies, several staff felt that the program lacked clearly defined guidelines for what was expected of peer advocates. One peer advocate explained, “When it started, I don’t think it was ever really well-defined, and I think that different places just kind of did whatever they did.”

Another peer advocate stated, “I'm aware of how I got this job, too, and I just don't think that they're always real selective on who's hired, and that comes in to what are you expecting from them? And different programs have different expectations from what they want the peer staff to do. I haven't gone for a while, but I used to go to those peer meetings downtown and stuff. There were some people that were still having a lot of real struggles and were having real difficulties doing the job.”

Several individuals thought that some peer advocates appeared to be unqualified for the job. They described them as lacking basic computer or social skills, or as having other skill deficits that have “nothing to do with mental health”. Consequently, a few peer advocates were perceived as not engaged in any part of the clinic culture. One individual said of a peer-advocate coworker, “[He] doesn’t move. I don’t know how he gets away with it...Just hang around here, and get paid.”

On the other end of the spectrum are peer advocates who are so highly-skilled that they essentially fulfill the job duties of higher-level staff. One peer advocate stated, “When our social worker left...I was basically given her entire caseload and says, ‘Here. This is yours now.’ So here I am, I’m doing everything that the licensed social worker is doing except...assessments...and...therapy...yet I’m applying the same techniques, the same formats. I’m using CBT, I’m using DBT....”

Another peer advocate reported, “I’m not a therapist, but for some reason I would get a lot of difficult people dumped on me sometimes.... The child molester was telling the doctor that they thought they needed some therapy. The social worker assigned to him just refused....There was another peer assigned to that person.”

Although clinic staff are aware of the major disparities in work responsibility, it is not clear how to resolve the issue. One supervisor stated, “So periodically we have a discussion, like the doctor brings up how unfair it is that these people are doing all this. So we have a discussion, but it’s kind of lightly, kind of like, yeah, talk to your union type of thing...I sympathize with that, and individually I encourage them to maybe go back to school or do whatever they can.”

Peer advocates who perform at this level of responsibility may see it as a “mixed blessing”. As one individual explained, “It’s a compliment to you that they’re trusting you to handle all sorts of things.” However, the biggest complaint cited by these high-performing peer advocates is the desire for a salary commensurate to their job performance.

Challenges: Lack of Career Path

Because all DMH salaries are tied to County item titles, there is little flexibility in how peer advocates can be paid. All advocates are paid the same salary as defined by the "Mental Health Peer Advocate" position. The only opportunity for promotion or salary increase is to advance to the "Community Worker" item, an entry-level position within DMH.

Promotion of a Peer Advocate to Community Worker is largely at the discretion of the supervisor. Once peer advocates have passed their six-month probation and have worked for a year, they are eligible for promotion. Out of the four peer advocates interviewed for this study, two have been promoted to Community Worker, both of whom had worked at least three years (prior to promotion or total) at the time of the interview. The other two peer advocates were not yet eligible, having worked at DMH for a year or less. The responsibilities of Peer Advocates promoted to Community Worker vary widely based on supervisor expectations.

Several interviewees suggested that the program's design is not conducive to long-term career development. According to one supervisor, "...the Department didn't know what to do with the peer positions for promotion." Positions above the Community Worker level, such as Medical Caseworker, require at least a bachelor's degree; many struggling with mental illness lack the resources or stability to pursue higher education. Furthermore, performance expectations for Community Workers (a position created for non-peers prior to the development of the Peer Advocate position) appear to be subjective and vary from peer to peer, and between consumer and non-consumer. There is a perception that when it became possible for Peer Advocates to be promoted to Community Workers, "they just kind of across the board promoted anybody that they wanted."

Technically, peer advocates can promote to any position within DMH, provided they have the education and years of experience required. At one clinic, a psychiatrist with a client background "very openly shares his own history." But several interviewees suggest that the requirements of most positions create barriers in a dead-end structure, in which peer advocates are shut out from higher advancement, despite their experience-based ability to provide specialized levels of care. As a result, a number of peer advocates are described as "rebelling against this process," due to the lack of opportunities for promotion.

Job titles and pay do not necessarily correspond with actual responsibility. One high-functioning peer advocate who is working at the level of a "junior social worker" has a bachelor's degree in another field; but, since s/he is not qualified in one of the social sciences, may remain a Community Worker indefinitely. One advocate states that, from her observations, people with a wide range of trainings and disciplines, from an entry-level worker to someone with a doctorate, may be doing "the same exact job" and yet "the reality is that the one with the less training and didn't have the same degree may be doing a better job than one of the ones that had it."

Supervisors agreed that the main differences between the Mental Health Peer Advocate and Community Worker positions are compensation and documentation. Each position uses a different documentation program. One supervisor also cited "just the innate pressure that comes with saying you're responsible for other human beings' care" as an additional responsibility associated with the Community Worker position". However, some peer advocates who have not been promoted to Community Worker are described as providing high levels of care.

In other instances, some consumers who have been promoted may feel ill-equipped to undertake a higher level of responsibility. One supervisor reported that "some of the expectations of a Community Worker are difficult for people that are promoted from a Peer Advocate to Community Worker, and some have suggested to me that, 'I wish I would have stayed a Peer Advocate to sort of stay at my own comfort level of responsibility.'"

Stigma

One of the objectives of this project was to identify the peer advocates' experience of stigma, and their and other staffers' perceptions of the impact of the program on reducing stigma. Although all four peer advocates interviewed self-disclosed their status, none of them made explicit references to experiencing stigma by others. However, stigma is often more likely to manifest implicitly. A peer advocate explained, "The staff was a little stand-offish at first, because they knew me as a peer advocate...and they were afraid that I wouldn't be able to handle it." Another peer advocate found that "the biggest challenge was I was very conscious of the fact that there was a lot of staff in the clinic that questioned the program, questioned hiring clients and stuff, and a lot of people that thought that the people or their illness would get in the way...so I made an effort to ensure that I was doing everything – doing it better than many people."

Stigma may also materialize within job assignments; "menial things" may be "dumped" on peer advocates by case managers or social workers. One peer advocate mentions that at other clinics, s/he had heard that peer advocates were merely used as "gophers". Peer advocates reported that the most job satisfaction comes from feeling that they are playing an integral role as part of a team.

Non-peer staff also recognized the emergence of stigma in covert ways, as an "undercurrent throughout." One non-peer coworker described the sense that peer advocates "don't seem to be very happy all the time. They just feel like somehow they ended up with the short end of the stick, or somehow they're being treated differently." Several staff indicated that stigma may manifest in "covert" ways and one supervisor stated his view that some other clinics exhibited a greater degree of stigma where it is "even intolerable and grievable in the sense that it is a form of discrimination."

In spite of these reports of stigma present within the clinics, non-peer respondents also described successfully navigating relationships with peer advocates. Some have become “good friends”, others are “normal co-workers”, while some peer-advocates were described as “just mean....it doesn’t matter they have a mental health issue.”

Non-peer coworkers may also take the peer’s status into consideration when making communication decisions. One individual remembered, “There was a Peer one time, he felt very left out. He said, ‘You guys never want to eat with me.’ And I felt bad. It wasn't because he was a Peer, it was because he was an older man; all of us are like in our twenties or thirties. It's something that you, as a co-worker, you're not concerned. But when it's a peer, you kind of have to think about that and be like, "Okay, I don't want them to feel left out. Let me go talk to him." But I know my old job was like I didn't care, you felt left out. You felt left out, you know?”

On the other hand, some staff also resisted the tendency to give peer advocates any special treatment. There is a pervasive sense that one “cannot say anything offensive to that person” due to his or her peer status; such diffidence may be perceived as unfair. Correspondingly, some non-peer staff also reported the view that peer-advocates operate at a different standard of professionalism, that they can “get away with” certain types of behavior that would otherwise not be acceptable for non-peer staff.

Several non-peer coworkers have had experiences where they felt they were not receiving support in conflict situations where a peer advocate was given preferential treatment. One non-peer coworker described an incident where a peer advocate had recurring episodes at the office, “rage attacks”, which he eventually reported to a supervisor. The non-peer coworker thought that appropriate actions were not taken and added, “I just want to feel safe while I’m at work. That behavior is unacceptable, and I cannot understand why everyone else accepts it and makes me look like I did something wrong because I complained.”

Disclosure

A peer worker who has experienced stigma may be reluctant to disclose their illness on the job. All four peer advocates interviewed in this study do self-disclose their illness. Because the Mental Health Peer Advocate’s original design requires at least 6 months of volunteering as a self-disclosing peer, all peer advocates working at DMH, at the time of this study, self-disclosed when they started working.

The Mental Health Peer Advocate program is premised on the understanding that self-disclosing peers use their lived experience to connect with and serve as role models to consumers receiving services. Commenting on the significance of the program, interviewees highlighted the peer’s ability to empathize with clients and serving as role models. One supervisor reported, “Sometimes a client maybe wouldn’t feel as comfortable talking to a professional who’s up in the hierarchy and there’s more of a power differential than [with] someone who’s sort of like them.”

However, despite the positive impact of self-disclosure and its centrality to the design of the program, some consumers have chosen to conceal their illness once they have been promoted to Community Worker. It is not clear whether this is a function of the stigma associated with being a peer or because the Community Worker position is a non-peer-specified entry-level position. Consumers may feel that the peer title marginalizes them from the rest of their colleagues who are not required to disclose a mental condition.

Although respondents respect the peer's decision of non-disclosure, they recognize the tensions involved. According to one supervisor, "This person is like the model of recovery, and you want to show that to your clients, but not at the person's expense...Maybe if I was going to hire my next Community Worker that I knew was a Peer Advocate before a Community Worker, I would make sure that I knew how defined they are about that role. I mean, it's not their fault. Nobody knew anything about how defined you were going to be in the role because it was all brand new, so brand new, and nobody had any idea of what to expect."

Non-disclosure can also be problematic if peer advocates have a relapsing or decompensating episode on the job. One individual, who was not informed about his coworker's peer status, was alarmed when the latter had an episode in their shared office space. He wondered, "Who's responsible if my co-worker's falling apart? I didn't get a briefing on that. When I showed up to work the first day, they didn't tell me, 'Oh, we're putting you in this room full of people that are mentally ill, but they have a job here, and you're going to work with them'...But I just feel like I should have had more of a briefing on [it]. But I guess they're protected."

Symptoms

Recovery is an evolving process and some peer advocates continue to cope with their illness as they interact in the workplace. One area of ambiguity is to what extent peer advocates should disclose to their supervisors symptoms that may interfere with their work. Peer advocates report struggling with delusions, depression, anxiety attacks, hearing voices, and sleep problems. Supervisors handle these reports in different ways. On one end of the spectrum, a supervisor may treat a mental health issue as any other personal issue, be it "babysitting issues or family issues," and prefer not to know the specific nature of the problem.

As one peer advocate reported about her experience dealing with delusions, she was told by her supervisor that she would not get any "special treatment" and "should have called in sick." In response, this peer advocate felt "sensitive and hurt" because she hoped for "a little bit more understanding," but eventually realized, "This could be something positive. She doesn't see me any differently than another employee. She sees me as an equal employee, which is good."

On the other end of the spectrum, a supervisor may provide more counsel and support when a peer advocate openly shares their symptoms. This allows for a more therapeutic than a professional relationship. It is important for peer advocates and their supervisors to clearly define what the expectations are in supervision when mental illness symptoms become problematic on the job.

Conclusion

On the basis of the data obtained from this small sample, the Peer Advocacy program has been quite successful at LACDMH and is perceived as a positive benefit to the clinics by both the peer advocates and their supervisors. Peers do report some residual stigma, or perceptions of stigma; and supervisors and co-workers report instances where peer workers are perceived as “getting special treatment” or where staff experience uncertainty when the peer worker exhibits symptomatic behaviors. The major issues identified, however, were disparities in workload and job expectations and lack of career paths available to Peer Workers.

Recommendations:

1) **Clarification of job responsibilities and expectations for Peer Advocates, while allowing each clinic flexibility to meet its own needs and best utilize its peer workers.**
2) **Job Planning workshops for Peer Advocates to help them learn new skills and identify career paths where they can use their existing abilities.**
3) **Clarification of expectations regarding:**
   a. **Community Worker self-disclosure**
   b. **Peer Advocate performance standards and sanctions**
   c. **Appropriate coworker and supervisor responses to symptomatic behaviors.**

Appendix A: Semi-Structured Interview Guides

1. For Peers:

What kinds of work do peer workers do?

What did they bring to the job; what do they see themselves as contributing?

How did they get their jobs? What training did they receive?

Who was most helpful to them in learning the job? How did this person help?

Of the people who trained them, what did the person (or people) who were helpful do that made them effective / valuable? What did the other person (or people) do (or not do) that made them not as helpful?

What benefits do they see themselves as having received from their jobs?

What problems do they encounter on the job on a regular basis?

What problems do they encounter on an occasional basis?

How did they solve these?

Do they know other peers who have encountered similar problems (both frequent and occasional problems)?

Do they see themselves as being on a career path? Where are they going?

Overall, what has worked well?

Overall, what has been the biggest challenge for them?

Overall, what changes would they recommend, if any?

2. For Clinic Directors/Supervisors:

How are the peer-workers trained?

What do you do to help them develop in their jobs?

What attributes do supervisors think the peer has brought to the job?

In what ways do they see the peer as contributing to the clinic?

What challenges have occurred with the worker?

How have these been worked out?

What clinic positions do supervisors see as available to peer-workers?

What positions may not be available and why?

What criteria do supervisors use in selecting/hiring peers?

What criteria do supervisors use in evaluating the work of peers?

Are there bureaucratic supports or impediments that you have noticed? Other supports that should be in place?

Appendix B: Description of Survey Measures

Attribution Questionnaire

The Attribution Questionnaire (AQ) is the measure used to test the nine factor path model outlined by Corrigan in explaining the relationship between public attitudes, corresponding affect, and resulting decisions related to people with mental illness test–retest and confirmatory factor analysis have demonstrated the reliability and validity of this model (Corrigan et al., 2002).

To complete the AQ, research participants are presented a very short and neutral statement about ‘‘Harry,’’ who works as a clerk in a law firm and has been hospitalized for schizophrenia. Other work by our group shows asking participants to respond to a specific person with mental illness, rather than to people with mental illness in general, leads to a more sensitive measure of attitudes that better corresponds with concurrent validators (Corrigan et al., 1999). Research participants then answer 27 AQ items about their response to Harry on a 9 point Likert Scale; e.g., ‘‘Harry would terrify me’’ (9 very much). Based on our earlier work, nine factor scores were obtained from the AQ to answer the questions of this study. (1) Responsibility; e.g., ‘‘Harry is to blame for his illness.’’; (2) Pity; e.g., ‘‘I would have sympathy for Harry.’’; (3) Anger; ‘‘Harry would make me angry.’’; (4) Dangerousness; e.g., ‘‘I would feel unsafe around Harry.’’; (5) Fear: e.g., ‘‘Harry would terrify me.’’; (6) Avoidance (reverse scored); e.g., ‘‘If I were an employer, I would interview Harry for a job.’’; (7) Coercion; e.g., ‘‘If I were in charge of Harry's treatment, I would require him to take his medication.’’; (8) Segregation; e.g., ‘‘I think it would be best for Harry's community if he were put away in a psychiatric hospital.’’; (9) No Help; ‘‘How likely is it that you would help Harry?’’ The scores in the AQ27 are determined by summing the three items determined by Corrigan et al. The highest score is 27 for each factor and higher the score, the more that factor is being endorsed by the subject.

Beliefs about Mental Illness

The Beliefs about Mental Illness (BMI) measure is a 35-item measure used to evaluate an individual's knowledge, beliefs / attitudes regarding mental illness. Questions are rated on a 5-point Likert scale from strongly disagree to strongly agree. Items for knowledge and beliefs / attitudes are randomly interspersed in a single questionnaire for ease of completion. In addition, reverse items were included in each scale such that correct knowledge or positive attitudes would be reflected by disagreement with the statement. Information regarding validity and reliability are not available but the measure was used for this project because the items in the measure reflect the study aims compared to other measures on internal and external stigma about mental illness or peers in mental health clinics.

Recovery Assessment Scale

The Recovery Assessment Scale (RAS) is a 41-item scale used to assess perceptions of recovery from severe mental illness with a 5-point Likert scale. The

RAS includes 5 factors: personal confidence and hope (e.g., “Fear doesn't stop me from living the way I want to”), willingness to ask for help (e.g., “I ask for help when I need it”), goal and success oriented (e.g., “I have goals in my life that I want to reach”), positive reliance on others (e.g., “I have people I can count on”), and not dominated by symptoms (e.g., “My symptoms interfere less and less with my life”). The highest score one can obtain in each factor are as follows; 45 for personal confidence and hope, 15 for willingness to ask for help, 25 for goal and success oriented, 20 for positive reliance on others, and 15 for not dominated by symptoms. Prior research on the RAS indicates high internal reliability (coefficient α = .93), test-retest reliability over 2 weeks (*r* = .88), and convergent validity with the Rosenberg Self-Esteem Scale, the Empowerment Scale, the Social Support Questionnaire, the subjective component of the Quality of Life Interview, and the Brief Psychiatric Rating Scale (*r* values = .55, −.71, .48, .62, and −.44, respectively) (Corrigan et al., 2004).

Stigma Scale

The Stigma Scale (SS) is a 28-item that assesses the role of stigma of psychiatric illness in research and clinical settings. The scoring was done on a 5-point Likert scale: strongly disagree to strongly agree. The measure has three subscales; discrimination (e.g. “Sometimes I feel that I am being talked down to because of my mental health problems”), disclosure (e.g. “I worry about telling people I receive psychological treatment”), and positive aspects (e.g. “People have been understanding of my mental health problems”).

Cronbach's α for responses to the 28 items of the final version was 0.87. No single item deletion improved the internal reliability above 0.88. Cronbach's α for the first sub-scale (discrimination) was 0.87; for the second (disclosure) 0.85 and for the third (positive aspects) 0.64. Mean scores were as follows: Stigma Scale 62.6 (s.d.=15.4), discrimination sub-scale 29.1 (s.d.=9.5), disclosure sub-scale 24.7 (s.d.=8.0) and positive aspects sub-scale 8.8 (s.d.=2.8).

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