MAS Muslim American Society
SACRAMENTO

CALIFORNIA REDUCING DISPARITIES PROJECT

SHIFA FOR TODAY

(HEALING FOR TODAY)

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Evaluation Report Prepared
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in collaboration with the
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EXECUTIVE SUMMARY

The Muslim American Society-Social Services Foundation's (MAS-SSF) mission is to aid families at large and the Muslim community with meeting their social service needs. Our vision is to be at the forefront of community social services in terms of provision of resources to support the community in attaining overall well-being. We are accomplishing our vision through a blend of prevention and early intervention (PEI) mental health programming and culturally competent, linguistically appropriate client-driven services. All services are steeped in community collaboration and aimed at connecting people to resources needed to recover.

Shifa for Today is an early intervention program designed by MAS-SSF that aims to reduce trauma, anxiety, depression, and suicidal thoughts among South Asian Muslim adults by developing a culturally competent mental health workforce, increasing access and utilization of mental health services, increasing social support, and decreasing psychological distress. It is designed to accommodate the cultural values and linguistic needs of South Asian Muslims as recommended by the Asian Pacific Islander report, developed by the Office of Health Equity and various stakeholders in Phase I of the California Reducing Disparities Project (CRDP).

Shifa for Today is a community-defined evidence practice that provides meaningful insights into reducing disparities and improving the quality and availability of mental health services and support for immigrants and refugees. This intervention that incorporates the use of psychoeducation and traditional spiritual and religious Islamic content and practices, peer support specialists (PSS) will use cultural, linguistic, and spiritual/religious approaches aligned with clients/consumers' beliefs, cultures, and languages to support them.

The purpose of this evaluation is to assess the program and workforce development components of *Shifa for Today.* These components include the recruitment and training of PSS

and the development of the *Shifa for Today* curriculum. Listed below are the evaluation questions:

- Evaluation Question 1: What prior knowledge, experiences do Peer Support Specialists have, as it pertains to peer support, prior to training?
- Evaluation Question 2: What characteristics or attributes do Peer Support Specialists have in common?
- Evaluation Question 3: What feedback do Peer Support Specialists offer following training?
- Evaluation Question 4: What modifications are made to *Shifa for Today* training following first and second cycle?
- Evaluation Question 5: What type of peer support and community engagement are Peer Support Specialists engaged in?
- Evaluation Question 6: How are Peer Support Specialists applying training knowledge to cases?

MAS-SSF employed a descriptive mixed-methods methodology with a community-based participatory research orientation to develop a formative evaluation to assess aspects of PSS training curriculum development, the training itself, and how PSS are engaged in the broader community. *Shifa for Today* took place between October 2016 – June 2021. Cycle 1 took place between November 2019 and June 2020 (n=20). Cycle 2 took place between June 2020 – June 2021 (n=6). Each cycle had a unique cohort associated with it. Both cohorts were part of the evaluation. Six focus groups were facilitated, four interviews were conducted, and two pre- and post-test assessments were administered. Focus groups and interviews centered on PSS's knowledge, skills, background, and perspectives on training. The pre- and post-tests assessed prior knowledge of key concepts related to peer support and knowledge acquisition of key peer support concepts following training.

Listed below are the overall findings:

- Finding 1: Peer Support Specialists are driven to provide peer support out of an intrinsic need to support others
- Finding 2: Peer Support Specialists entered *Shifa for Today* with skill, education, and lived experience
- Finding 3: *Shifa for Today* training curriculum and delivery provided valuable conceptual and theoretical tools for Peer Support Specialists
- Finding 4: Peer Support Specialists lack sufficient hands-on, practical experiences in *Shifa for Today* training

The findings of this evaluation provide insights into recruitment and screening of volunteer peer specialists, curriculum development, and training. A clear bright spot of this project is having PSS with lived experience that will likely align the clients' needs and experiences. The PSS were candid about their personal experiences and challenges and their desire to "walk with others" as they work through the challenges that brought them to MAS-SSF.

The delivery of a curriculum culturally tailored for South Asian Muslims (SAM) appears to have been timely and relatable. The PSS desired to have more training on culture. The difficulty of including more detail on culture is that there are so many cultures, nuances and intersecting identities associated with each client's culture. Finding methods of infusing more cultural training into the curriculum and determining the correct balance for the training will be helpful in the future. Understanding how the culturally tailored curriculum from this project modifies patient outcomes will also be an important area of evaluation.

The lack of hands-on training was a deficit of this project. The type of hands-on training the PSS requested was learning by doing. This type of training goes beyond learning by doing as it has been found to be emotionally engaging and transformative. Creating more opportunities for more experiential, hands-on training of PSS is recommended to be included in next iterations of

training. A material change that has been made to the curriculum is that role plays have been added to each module in the *Shifa for Today* curriculum. More changes are being considered.

Shifa for Today reflects the intricacies of developing a culturally tailored peer support program for South Asian Muslims. Having skilled peer support specialists, a well-developed curriculum, and an engaging training aided in building a peer support program poised to improve health outcomes and reduce disparities. The findings from this evaluation illuminate valuable insights to consider as MAS-SSF continues to grow *Shifa for Today*.

Definitions

Community defined evidence practice - Knowledge accumulated through the ongoing successful implementation and/or evaluation of practices developed locally with significant community input.[1]

Culture – The social behavior and norms found in human societies, as well as the knowledge, beliefs, arts, laws, customs, capabilities, and habits of the individuals in these groups.

Cultural tailoring – Adaptation of messages, strategies, and materials to fit specific cultural characteristics.

Muslim – A person or people who follow the practices of Islam.

Peer Support - The provision of social emotional support by persons sharing a similar mental health condition to aid in bringing about a desired social or personal change.[2]

Peer Support Specialist – A person who has been successful in the recovery process who help others experiencing similar situations.[3]

South Asian ethnic group – Diverse set of ethnic groups that include, but not limited to, people from India, Pakistan, Bangladesh, and Afghanistan. Although Afghanistan is in Central Asia, Afghans are grouped, at times, with South Asians. Each group has their own culture and sub-culture and linguistic traditions.

Introduction

Immigrants and refugees face many difficulties settling into their new environment.[4] At times, these difficulties result in emotional problems and social emotional adjustment challenges. The events leading up to resettlement or displacement can be filled with violence, threats, or war. In some cases, refugees will have been subject to either direct or indirect trauma. Those from collectivistic cultures will often share that trauma, discrimination, and oppression as a collective identity. Similarly, immigrants usually face similar and contrasting hardships by arriving to unfriendly or unjust conditions and being at the lower rungs of society.[5]

These social and mental health issues are further aggravated by the lack of culturally, linguistically, and spiritually/religiously sensitive mental health services,[6] fear of seeking services due to anti-Muslim bigotry,[7] and cultural stigma against seeking services. The extent of the experience of hostility in the public arena makes it challenging for many Muslim-Americans to develop healthy communal life. An understanding of religious and cultural differences, social customs, and values is necessary when conducting psychotherapy with any community but is very important for South Asian communities. Unfortunately, there remains a dearth of data in this area because attempts to offer mental health services tailored to the specific socio-cultural needs of Muslim Americans of various ethnic backgrounds have only been made in recent decades.[8]

Culturally-based discrimination, stigma, and shame deprive Muslims of seeking and receiving the professional care they need. These impediments faced by South Asian Muslims (SAM) discourage them from seeking professional help, thus causing them and their families unmanaged psychological distress and further suffering.[9,10,11] Another potential obstacle for SAM men and women is the lack of permission or approval they receive from extended family members who may be offended by the notion of seeking formal help from someone outside the

family, considered a cultural taboo. The need to protect, or honor, their "izzat," constructs another barrier for SAM; this burden to protect "izzat" is disproportionately placed on women, who may avoid seeking professional mental health services out of fear of tarnishing their individual and family's reputations.[12]

It is estimated that a quarter of Pakistanis who participated in a recent study conducted in the Sacramento area had experienced past trauma in their country of origin and current trauma in the US.[13] Given the influx in Sacramento of recent refugees from Syria, Afghanistan, and parts of Africa, it is imperative to better identify the additional challenges they encounter in accessing necessary mental health services. MAS-SSF's peer support records show that about 50% of SAM clients/consumers suffer from post-traumatic stress disorder (PTSD) symptoms when assessed for counseling. Other symptoms reported by clients/consumers include symptoms of anxiety (in more than 10% of clients/consumers) and suicidal thoughts (30% of clients/consumers). With the rise of anti-Muslim bigotry, counselors expect to see more clients/consumers suffering from psychosocial stressors, which might trigger the onset of symptoms of low self-esteem, anxiety, PTSD, and depression.

Acculturation problems are frequently seen in SAM clients/consumers. Acculturation speaks to the balancing of two cultures while adapting to the dominant culture. At the core of acculturation is culture, which is complex and difficult to define. Culture can include very visible things such as artifacts and behaviors as well as fundamental attitudes, beliefs, and values.[14] Research suggests a paradox found in the concept of acculturation because it is noted to improve mental health and damage mental health.[15,16,17,18]

More than 90% of SAM clients/consumers seen by MAS-SSF's PSS reported suffering from emotional distress due to challenges faced in their efforts to adjust to the American system.

Gender discrimination is a source of trauma for some immigrant women who have lost the social companionship and support they had in their home country before being brought to the United States by husbands and in-laws who expect them to maintain subservient roles as housewife and caregiver to the in-laws.[19] Other educated SAM women find difficulty balancing work and family. These challenges and stressors can be significant, especially in stressful conditions of learning a new culture. Therefore, family conflicts are high among SAM clients/consumers (20% of MAS-SSF clients/consumers). This could result in emotional, physical, and verbal abuse estimated to be affecting 18% of SAM clients/consumers.

An initial needs assessment was done by MAS-SSF for Sacramento Muslims in 2006-2007. In that assessment, 70% of the 120 Muslims who responded indicated that counseling services for marriage, parenting, and teen issues were needed. Yet, while those respondents recognized this need, cultural and social stigma often discourages SAMs in distress from help-seeking actions or seeking help outside the family.[2]

Despite these challenges, it is important not to label all refugees or immigrants as having suffered from mental illness or distress.[20] Immigrants and refugees off all backgrounds are typically stereotyped as ignorant, prone to disease, criminality, and insanity.[14] It is true that immigrants and refugees have likely lived through extraordinary circumstances, but the population must be viewed broadly for its culture, strengths, and the context (e.g., political, social, economic) they have arrived in. Strengths-based approaches that are culturally appropriate, flexible, and tailored to the community are fitting for this population.[21,22] Peer support is a promising practice.

Research suggests that peer support programs, like *Shifa for Today*, can provide an opportunity for people from similar backgrounds (peer support specialists) --those with their own

lived experience of recovery and resilience from trauma and those without those experiences but with a shared cultural understanding--to assist other clients/consumers in their journey to recovery and healing. PSS can model recovery and resilience, offer support, and teach skills to others experiencing mental health challenges so that they may lead successful and meaningful lives in their communities. PSS can empower the client/consumer, enhance their sense of hope, aid in system navigation, and promote healing and recovery through peer support. MAS-SSF has found that some peer counselors also use their own lived experience of recovery from mental health challenges to support others in recovery. The PSS's perspective and role put them in a unique position to offer their personal knowledge and support and be effective in counseling, in a way that someone without that same shared background and understanding could not.[23] In addition, PSS may have innovative approaches in helping clients/consumers with access and utilization of healthcare services.[3]

The Muslim American Society-Social Services Foundation's (MAS-SSF) mission is to aid families at large and the Muslim community with meeting their social service needs. Our vision is to be at the forefront of community social services in terms of provision of resources to support the community in attaining overall well-being. We are accomplishing our vision through a blend of prevention and early intervention (PEI) mental health programming and culturally competent, linguistically appropriate client-driven services. All services are steeped in community collaboration and aimed at connecting people to resources needed to recover.

MAS-SSF was created in 2007 to respond to the unmet community need for mental health prevention and early intervention with culturally, linguistically, and spiritually competent services. The organization has trained volunteer PSS over the past 10 years through a variety of methods (including role playing, watching counseling videos, presentations on ethics, and talks

by guest speakers from the field of mental health and social services, with a specialization in working with the Muslim community). Training occurred with the support of various Muslim social services experts and scholars. In 2007, when it was started, MAS-SSF trained volunteer PSS on cultural, spiritual, and religious content, in addition to basic PSS training. In 2016, MAS-SSF trained its second group/cohort of volunteer PSS through an in-depth certified peer support training, but that training did not include the cultural, spiritual, and religious content delivered before.

This evaluation report describes the evaluation of the *Shifa for Today* program. A literature review of relevant literature related to culturally tailored peer support among immigrants and refugees will be presented. The study design will be described along with the data collection measures and procedures. The findings will be presented based on the corresponding evaluation question. Finally, the findings will be discussed and recommendations for future actions will be provided.

Literature Review

Peer Support in Mental Health

Innovative approaches to aiding immigrants and refugees with mental health support are community-based interventions that provide a comfortable, safe space for sharing and empowering through peer support.[24,25,26] Peer support is defined as the provision of social emotional support by persons sharing a similar mental health condition to aid in bringing about a desired social or personal change.[27,28,29,30,31] Peer support is not based in psychiatric or clinical models; instead, it centers on understanding another's situation through empathy, support, and a lens of a shared experience of emotional and psychological pain.[32] Peers use their own lived experiences of overcoming mental distress to support another through their own struggles. In essence, peer support means walking with clients as they work through their challenges.

The key premise that makes peer support so attractive are the benefits one receives when they find support through a connection outside of an expert/patient relationship. That is, when people find and feel connection with someone who is like them based on mutual experience, trust builds and the opportunity for mutual empowerment grows. The support of peers serves as a natural extension and expansion of community rather than reinforcing the professionalized model of caretaking in mental health support. It spurs movement toward autonomy and community because peers learn to see their problems in the context of a larger system (e.g., social, political, economic) that helps move them away from seeing themselves as damaged, different, or ill. In essence, the relationship between peers is centered on reciprocity and building up a synergistic relationship between both parties.

Peer support has been shown to be beneficial in other chronically ill populations such as people living with diabetes, HIV, cancer, and heart disease.[33,34,35,36] In cancer support, peer support aids patients in receiving experiential empathy that often goes beyond the scope of health professionals.[37,38] Moreover, patients with peer support have been found to have improved satisfaction in their medical care, increased sense of belonging, improved mood, and better personal relationships.[39] However, adverse outcomes from peer support have also been found, including reinforcement of poor behaviors and lower feelings of self-efficacy.[40] Research on peer support among HIV patients found consistent themes of acceptance, reciprocal support, and personal growth and empowerment.[41]

Culturally Tailored Peer Support

While there is no single description of what makes the best peer support, peer support is often wanted and most useful from "people like me".[42] A shared or similar culture is key to peer support as social support is influenced by cultural values and norms.[43] A critical part of the lived experience peer support specialists provide is experience living and existing within the same or a

similar culture. Current research on peer support reflects resounding evidence of the importance of building out culturally tailored peer support programming to enhance outcomes and reduce unintended consequences and exacerbating challenges.

Culturally appropriate and tailored interventions require the adaptation of messages, strategies, and materials to fit specific cultural characteristics.[44,45] Patients at risk for poor health disparities experience a "double burden" due to a lack of understanding from clinicians on how race, ethnicity, and nationality further influence their experiences and health outcomes. There are many patient populations who report significant barriers to culturally competent care.[46] As a result, a one-size-fits-all approach will not work.[47]

A peer support program in South Africa for people with diabetes reported deeply religious women with disease associated their disease with a sin or being a victim of witchcraft. As a result, the program incorporated singing and praying at the beginning and ending of peer support sessions.[48] A study of peer support to support SAM adults who had recently migrated to the U.S. found that peer support specialists (called community ambassadors) served a hybrid role of family-life and professional support where they navigated the sensitive interplay between the elders, their adult children, and community resources.[49] In Denmark, displaced women participated in a mutual support club of women with the same experiences. The club was described as a place for well-being and stimulated feelings of being part of a family and community and an aid for coping with loneliness.[50]

In some instances, similarity of diagnostic history or category is not necessary. A study of a postpartum depression intervention implemented among rural Pakistani women drew peer support from women from the same village but who did not necessarily have a shared history of postpartum depression or depression.[51] This point underscores the wider range of lived

experience that can exist among peer support specialists. Broadening the scope of who "people like me" can be in the peer support context is beneficial for managing the delicate interplay between individuals with many intersecting identities. Beyond the immediate impact that direct peer support provides, community engagement is a benefit of peer support programs.[52,53] Research reflects that peer support aids in building relationships and greater community integration like stronger familial relationships, friendships, spiritual/religious alignment, leisure, and civic life occur.[54]

Community-Defined Evidence Practice

Purpose

Shifa for Today is an early intervention program that aims to reduce trauma, anxiety, depression, and suicidal thoughts among SAM adults by developing a culturally competent mental health workforce, increasing access and utilization of mental health services, increasing social support, and decreasing psychological distress. It is designed to accommodate the cultural values and linguistic needs of SAM as recommended by the Asian Pacific Islander report, developed by the Office of Health Equity and various stakeholders in Phase I of the California Reducing Disparities Project (CRDP).

Through this intervention that incorporates the use of psychoeducation and traditional spiritual and religious Islamic content and practices, PSS will use cultural, linguistic, and spiritual/religious approaches aligned with clients/consumers' beliefs to support them.

Description and Implementation

Component 1: Peer Support Specialist Recruitment & Screening

The purpose of Component 1 is to recruit and screen a diverse pool of PSSs to serve clients of diverse backgrounds. This component was implemented in June 2018. PSS diversity is based in range of variables including nationality, language, gender, age, and lived experience. PSS were recruited via word-of-mouth, tabling at community events, announcements during Mosque events, flyers, community partner referral, the MAS-SSF e-blog, and previous experience or engagement with MAS-SSF. Preferred candidates were individuals with innate or learned qualities of resilience, strength, sensitivity, understanding, and compassion gained through their own traumatic life experiences, mental health challenges, and adverse life experiences or from other experiences. Those individuals with lived experiences with mental

health challenges may be able to effectively share with others how they have navigated and maintain their recovery. Those individuals can use their recovery experience as a framework to understand and support clients/consumers in their own recovery journey and process, in a professional, personal, and competent manner supported by their initial and ongoing training. While there were no outright exclusion criteria, potential PSS were excluded if they submitted an incomplete application that did not describe their lived experience or they did not have sufficient education.

Once they applied, the potential PSS was screened during an interview with the same set of questions [**Appendix A**]. The questions were designed to assess lived experience, sensibilities for peer support, and motivation for being a PSS. Potential PSS were assessed by MAS-SSF staff and some board members. Potential PSS were assessed on the information provided in their application and the content of their interview. The interview centered on a set of questions that delved into their involvement in the Muslim community, rationale for wanting to become a PSS, and their response to a situational question. MAS-SSF were generous in their assessment and ultimately were looking for people with lived experience who were interested in learning. Once a potential PSS was screened, they were either invited to join the upcoming cohort or not invited to participate.

Component 2: Peer Support Specialist Training Curriculum Development

Shifa for Today was designed to complement existing peer specialist training that all certified peer specialists receive. The *Shifa for Today* curriculum development was a significant part of this study. The curriculum development process of securing a subject matter expert started in 2017 and was prolonged due to several challenges. The most prominent challenge was working through the process of ownership of the curriculum once developed. The CRDP program is funding the development of this curriculum and there was question of who owned the intellectual

property. Settling this matter took several months. Additionally, there were delays related to this issue and the internal review of the content. The curriculum was completed in May 2019.

Prior to receiving in the *Shifa for Today* training, all PSS became certified peer specialists. Training was provided by RI International for Cycle 1 and CalVoices for Cycle 2. RI International and CalVoices are different agencies that provide the same or similar 80-hour peer specialist certification training. The peer specialist certification is a standardized curriculum of training on mental health, coaching, documentation, communication skills, and ethics. CalVoices requires an additional 20 hours of field practice within a peer support organization like MAS-SSF and Mental Health First Aid Training.

To provide a standard, culturally relevant training for PSSs, MAS-SSF set out to develop an original training curriculum for the *Shifa for Today* model and program. MAS-SSF identified five core practices that it would like to incorporate into a more formal PSS training for its *Shifa for Today* program:

1) Communicating non-judgmental understanding to clients/consumers;
2) Employing and providing diverse potentially beneficial Islamic religious and spiritual content and practices to clients/consumers;
3) Honoring family context and cultural considerations in an ethical manner when they promote healthy family relationships and dynamics;
4) Providing counseling in the native language of the clients/consumers; and
5) Using flexible practices to accommodate the diverse prevention and early intervention mental health needs of clients/consumers.

For each of the five core practices, MAS-SSF planned to define and describe what the PSS needed to know and how the peer support would apply it in the peer support session. For

example, for the second core practice focused on Islamic religious and spiritual content and practices, examples of Islamic practices and cultural practices include: Qur'anic verses, *Hadiths* (collection of traditions containing sayings of the Prophet Muhammad (pbuh)), *Seerah* (stories from the life of the Prophet Muhammad (pbuh)), *Duaa* (voluntary prayers/supplications), and *Dhikr* (remembering God and His attributes), the use of a *misbaha* or prayer beads for dhikr, listening to and/or performing *salat* (formal prayers), cultural poetry, including Qawwali, Nasheed, Naat, Gnawa, El Hamdouchiyya, Muslim hip-hop and rap music, as well as Rumi's Sufi poetry. In addition to the cultural, religious, and spiritual elements, MAS-SSF needed to incorporate and condense the essentials of a standard peer support training into the *Shifa for Today* curriculum.

MAS-SSF engaged Lisa St. George as the subject matter expert to develop and deliver the *Shifa for Today* curriculum. Mrs. St. George has over 40 years of experience in health and human services with expertise in leading large peer support programs. She is also of Islamic faith. Mrs. St. George situated the *Shifa for Today* into a 32-hour training of four 4-hour Saturday sessions. The curriculum was reviewed internally by the MAS-SSF evaluation committee for consistency with Islamic practices and quality.

Component 3: Training of Peer Support Specialists

The purpose of Component 3 was to provide training for PSS to aid them in supporting and empowering immigrants and refugees of the SAM community. Cycle 1 took place between November 2019 and June 2020. Cycle 2 took place between June 2020 – June 2021. PSS training was designed to be offered at MAS-SSF's office training room. The first two sessions would include a training on the recovery model, peer support skills and concepts, working with refugee populations, and how to recognize serious psychological symptoms that may require a referral to

a professional. The last two sessions would focus on the cultural and spiritual practices specific to *Shifa for Today's* peer support sessions, as well as how to conduct assessments and monitor progress. There were also specialized follow-up trainings, consultation, and resources available to PSS to increase their understanding of the continuum of behavioral health needs of clients/consumers and families. To ensure continuity in the program for clients, PSS were asked to make a commitment of two years of availability to provide peer support.

The training for Cohort 1 was facilitated by Mrs. St. George in-person over two weekends sixteen hours each weekend. Cohort 2 was held on consecutive weeknights across two weeks 4 hours per night on Zoom due to the COVID-19 pandemic. In their training, PSS focused on the shared interest of helping clients/consumers recover and heal with an emphasis on the shared dedication to heal from the historical, cultural, political, and intergenerational traumas putting them at higher risk for mental illness to foster the beginning of building trust and rapport. The training and counseling program also highlighted the following:

- Acculturative stress; migration and resettlement trauma
- Risk for Post-Traumatic Stress Disorder
- Cultural components of psychosocial environment
- Family psychosocial factors
- Intergenerational and personal trauma from British colonization, 1947 partition, Afghan wars, Kashmir situation, Gujarat riots, immigration history, refugee status, post-9/11 anxiety, conversion to Islam, discrimination, stereotyping
- Cultural considerations: Muslim women, immigrant/refugee issues, cultural adjustment, domestic violence, child abuse; intersectionalities of gendered violence; risk of

depression for men and women whose income and socio-cultural status has dropped from satisfactory to unsatisfactory as a result of migration.

- Continuum of religiosity: Identify the various complexities of faith (i.e., born a Muslim but do not follow any of its tenets; Islam is an integral part of my life that I live and breathe, etc.)
- Intercultural and intracultural transference and countertransference
- Distrust, hesitance, and fear to share for fear of being shamed or stereotyped, facing stigma

Moreover, PSS were trained to be cognizant of the boundaries between peer support and clinical treatment. They were provided resources to make referrals when appropriate. Following their training, some PSS have been engaged in providing peer support to MAS-SSF clients. Others have been engaged in MAS-SSF program and continuing education around peer support.

Component 4: Community Engagement

The purpose of Component 4 was to continuously engage PSS in MAS-SSF activities and the broader Muslim community to enhance knowledge of mental health and reduce stigma. Engaging PSS in the broader community provided an opportunity to build natural connections to the broader Muslim community. PSS were invited to participate in MAS-SSF events including Al Afiya, Marriage Events, the Family Day events, and many continuing education workshops provided throughout the year. The continuing education workshops were diverse in subject matter and designed to be as inclusive as possible. There were events for youth, parents, families, and seniors. MAS-SSF provided translation to most regularly spoken languages such as Urdu, Pashto, Dari, Arabic, Hindi, Punjabi, and others. The events served as an opportunity for relationship building and keeping the PSS engaged with MAS-SSF and the community.

Local Evaluation Questions

The local evaluation questions were updated mid-way through the project period to align more closely with the project activities. Part of the CRDP grant funds provided for capacity building which MAS-SSF engaged in fully through the first two and half years of the program. Mid-way through the funding period, a closer look was given to the original evaluation questions listed below:

- Original Evaluation Question 1: What are the defining cultural and spiritual values, practices, and traditions for the Shifa for Today curriculum and training model?
- Original Evaluation Question 2: What criteria are used to select peer support specialists from the South Asian Muslim Community?
- Original Evaluation Question 3: To what extend is the Shifa for Today curriculum effective with training individuals to become peer support specialists.

After reviewing the original questions, it was found that the questions needed to be refined to evaluate the prior knowledge and background of PSS, characteristics, feedback from training, modifications made to training, application of new knowledge, and community engagement. The following process evaluation questions were adopted in 2018.

- Evaluation Question 1: What prior knowledge, experiences do peer support specialists have, as it pertains to peer support, prior to training?
- Evaluation Question 2: What characteristics or attributes do peer support specialists have in common?
- Evaluation Question 3: What feedback do peer support specialists offer following training?
- Evaluation Question 4: What modifications are made to *Shifa for Today* training following first and second cycle?
- Evaluation Question 5: What type of peer support and community engagement are peer counselors engaged in?
- Evaluation Question 6: How are peer support specialists applying training knowledge to cases?

Evaluation Design & Methods

MAS-SSF employed a descriptive mixed-methods methodology with a community-based participatory research orientation to developing a formative evaluation to assess aspects of PSS training curriculum development, the training itself, and how PSS are engaged in the broader community. The *Shifa for Today* evaluation was designed utilizing community-based participatory research (CBPR) principles. CBPR is an orientation to health research that combines the knowledge and actions of partners equitably through co-learning, partnering, and capacity building to arrive at products that are important and useful to the improving community health and eliminating health disparities.[55]

CBPR exists along a continuum that begins at the initiation of the study and concludes with the dissemination of findings and knowledge gained by all partners. Throughout this process, multiple partners with the MAS-SSF community were engaged to help support the development of *Shifa for Today* and the evaluation. The partners involved in this partnership included the MAS-SSF Evaluation Committee, the local evaluator, members of the Office of Health Equity at the California Department of Public Health, and technical assistance providers at Special Service for Groups Research & Evaluation (SSG). The MAS-SSF Evaluation Committee is composed of different stakeholders (a board director, administrative staff, Lead Peer Counselor, client/consumer, family members, volunteers) to ensure that internal stakeholders will help design and implement the evaluation process. The Evaluation Committee received training from the local evaluator and from the technical assistance team in preparation of becoming involved in all steps of the evaluation process.

Moreover, this evaluation design includes an intersectional approach that acknowledges the many identities of members of the SAM community. The population MAS-SSF is serving are SAMs who come from different ethnic and religious backgrounds. SAMs have ancestries tracing

back to different countries including Afghanistan, Bangladesh, Bhutan, India, Iran, the Maldives, Nepal, Pakistan, and Sri Lanka. Their Islamic background might reflect various sects: Sunnis and Shi'as. Economic background varies. Members of our communities have unique gender identities, gender expressions, and sexualities that we also take into consideration.

Human Subjects Protections

The Committee for the Protection of Human Subjects (CPHS) approved a 'Request for Determination' to exempt MAS-SSF from submitting a formal Institutional Review Board application for this study on the basis that it is an evaluation and not research. This project is Exempt and did not require CPHS approval to be conducted. This decision was issued under CPHS' Federal wide Assurance #00000681 with the Office of Human Research Protections.

Design

A mixed-methods approach was employed to answer the evaluation questions. This form of evaluation utilizes a combination of quantitative and qualitative approaches to provide greater understanding of the phenomena than either method can provide alone.[56] Mixed-methods approaches to evaluation and research are useful approaches for producing a more complete picture of the phenomena under study.[57]

Qualitative Strand

The qualitative strand was guided by the following research question and objectives:

- Evaluation Question 1: What prior knowledge, experiences do Peer Support Specialists have, as it pertains to peer support, prior to training?
- Evaluation Question 2: What characteristics or attributes do Peer Support Specialists have in common?
- Evaluation Question 3: What feedback do Peer Support Specialists offer following training?
- Evaluation Question 4: What modifications are made to *Shifa for Today* training following first and second cycle?

- Evaluation Question 5: What type of peer support and community engagement are Peer Support Specialists engaged in?

- Evaluation Question 6: How are peer support specialists applying training knowledge to cases?

A descriptive methodology was selected for its clear potential for triangulation with the quantitative data. Descriptions of how PSS experience the peer support training and subsequent activities were obtained. A qualitative descriptive methodology was selected as the best possible method for this evaluation because it is pragmatic in nature and allows the evaluator to stay close to the informants' point of view.[58,59]

Quantitative Strand

The quantitative strand was guided by the following research question and objectives:

- Evaluation Question 1: What prior knowledge, experiences do Peer Support Specialists have, as it pertains to peer support, prior to training?

- Evaluation Question 4: What modifications are made to *Shifa for Today* training following first and second cycle?

This strand utilized a descriptive, single-group design. It will describe participants' understanding of peer support concepts prior to participating in the training and following their participation in training.

Sampling Methods and Size

Shifa for Today took place between October 2016 – June 2021. Cycle 1 took place between November 2019 and June 2020 (n=20). Cycle 2 took place between June 2020 – June 2021 (n=6). It is worth noting that the second cycle is smaller than the previous; a potential explanation of this is the impact of COVID-19 and the timing of training. Training was timed to happened directly before a religious holiday which might have made it inconvenient for prospective PSS to apply and participate. Each cycle has a unique cohort associated with it. Both

cohorts were part of the evaluation. Cycle 2 had significantly less PSS; however, the PSS that were trained were representative of MAS-SSF's general population.

Attrition

There was limited attrition in the recruitment and training stages. One person was unable to participate in training due to a family issue. All other PSS who signed up to participate in training fulfilled their commitment. An expected reason for the follow-through by the PSS is that, within the religion, each person is required to do charity either financially or in-kind. Second, the training was valued at $1,000 to $3,000. Although PSS were not asked to pay that, they were required to put down a $100 deposit (that they received back) to secure their spot. After training, some PSS did fall out of the program because there were not enough cases. MAS-SSF suspects that, due to stigma and then the COVID-19 pandemic, people were not taking up *Shifa for Today* services. The lack of cases meant that the PSS were not able to commit to charity in the way they needed. As a result, they turned to other charity within MAS-SSF such as outreach and engagement.

Fidelity and Flexibility

Shifa for Today was implemented as designed; however, the timeline was adjusted numerous times throughout the project to accommodate organizational needs and the COVID-19 pandemic. Participants were exposed to the planned number of sessions. A key modification was the way in which they were engaged. Cycle 1 PSS had an in-person training across several weekends while Cycle PSS participated in virtual trainings during the week in the evening. The quality of delivery was consistent; however, PSS certification training was provided by different vendors. The training Cycle 1 received from RI International was facilitated by Lisa St. George, the developer and facilitator of the Shifa for Today curriculum so that cohort had more exposure

to Mrs. St. George. MAS-SSF suspects that the groups facilitated by Mrs. St. George experience great application of the knowledge to their practice as PSS.

Measures & Data Collection Procedures

Data collection for the qualitative and quantitative strands took place between November 2019 to June 2021. The qualitative sample (n =20) and quantitative sample (n =6) participated in the evaluation. PSS were engaged in focus groups, individual interviews, and pre- and post-tests.

Focus Groups

Six focus groups were facilitated. Core practices focus groups occurred after PSS participated in *Shifa for Today*. The purpose of the core practices focus group was to gather PSS perspectives and opinions on the peer support training. PSSs were invited to voluntarily participate in the focus groups through e-mail invitations from the MAS-SSF staff. Each focus group was facilitated via the Zoom platform. The core practices focus group protocol [**Appendix B**] was developed specifically for this evaluation. Each session was record with the permission of participants and detailed notes were prepared for analysis. All data were de-identified and stored in a password protected cloud storage.

Date	Focus Group	# Of Participants
November 7, 2020	Core Practices	4
November 14, 2020	Core Practices	7
December 6, 2020	Core Practices	6
June 1, 2021	Core Practices	5
June 21, 2021	Closeout	4
June 30, 2021	Closeout	5

Table 1: Total Focus Groups

The closeout focus group sought to understand the overall experience of participants in *Shifa for Today* who had taken cases and who had not. PSS were invited to voluntarily participate in the focus groups through e-mail invitations from the MAS-SSF staff. Each focus group was facilitated via the Zoom platform. The closeout focus group protocol [**Appendix C**] was developed specifically for this evaluation. Each session lasted 60 to 90 minutes and was recorded with the permission of participants and

detailed notes were prepared for analysis. The session was facilitated in English. All data were de-identified and stored in a password protected cloud storage.

Individual Interviews

Individual semi-structured interviews were conducted in instances when a PSS could not participate in a focus group. A total of four interviews were conducted with the PSS utilizing the closeout protocol [**Appendix C**]. Unlike the focus group conversations, participants were able to reveal their opinions without the influence of others. Each interview was facilitated via Zoom and took approximately 30 minutes and was recorded with the permission of participants and detailed notes were prepared for analysis. The interviews were facilitated in English.

Pre- and Post-Test

PSS took two pre- and post-tests. In using a pre- and post-test design, PSS are exposed to the intervention, *Shifa for Today* curriculum, and then post-tested. The purpose is to assess changes in understanding and/or improvements. The Recovery Knowledge Inventory (RKI) [**Appendix D**] is an instrument designed to assess the knowledge of and attitudes of providers of mental health treatment toward recovery-oriented practices.[60,61] The RKI is organized in the following four domains:

1) Roles and responsibilities in recovery,
2) Non-linearity of the recovery process,
3) The roles of self-definition and peers in recovery, and
4) Expectations regarding recovery.

The RKI was selected to understand PSS attitudes toward recovery before and after their training. Studies have argued that providers of mental health services carry pessimistic, prejudiced, or poor attitudes toward recovery.[62],[63],[64],[65] These types of negative attitudes toward recovery can be detrimental in clinical and peer support settings. Providers' knowledge and

attitudes regarding recovery impact their interactions and attitudes.[66] As result, assessing PSS attitudes is appropriate. Although similar inventories exist, the RKI is the most influential and predominately used.[67]

The pre-test was administered online via Qualtrics prior to commencing training. The post-test was administered at the end of training online via Qualtrics. The RKI was administered in English and not translated in any other language. PSS were originally given 15 minutes to complete both pre- and post-tests; however, as Table 3 illustrates, it took PSS between 13 and 18 minutes to complete each assessment. A possible explanation for the unexpected time to take each assessment was language and the nature of the subject matter.

Average Time Taken on Pre- and Post-Test		
Cycle 1	Recovery Knowledge Inventory (Pre-Test)	13.23 minutes
Cycle 1	Recovery Knowledge Inventory (Post-Test)	15:36 minutes
Cycle 1	Shifa for Today Assessment (Pre-Test)	23:29 minutes
Cycle 1	Shifa for Today Assessment (Post-Test)	30:52 minutes
Cycle 2	Recovery Knowledge Inventory (Pre-Test)	14:55 minutes
Cycle 2	Recovery Knowledge Inventory (Post-Test)	18:19 minutes
Cycle 2	Shifa for Today Assessment (Pre-Test)	27:41 minutes
Cycle 2	Shifa for Today Assessment (Post-Test)	35:22 minutes

Table 2: Average Time Taken on Pre- and Post-Test

The *Shifa for Today Assessment* [**Appendix E**] pre- and post-test is an original assessment designed for this program. The *Shifa for Today* was primarily designed by Lisa St. George, the subject matter expert who developed and delivered the *Shifa for Today* training. The assessment included multiple choice questions related to concepts the PSS would learn during the training. The concepts included in the assessment were purposefully chosen to include items that were common sense-type questions and designed to elicit the PSS's perspective on the role of a PSS.

The pre-test was administered online via Qualtrics prior to commencing training. The post-test was administered at the end of training online via Qualtrics. The *Shifa for Today*

Assessment was administered in English and not translated in any other language. PSS were originally given 15 minutes to complete both pre- and post-tests; however, as Table 3 illustrates, it took PSS between 23 and 35 minutes to complete each assessment. A possible explanation for the unexpected time to take each assessment was language and the nature of the subject matter.

Data Analyses Plan Implemented

Thematic analysis was employed to analyze the data. Thematic analysis is a systematic method for identifying and organizing data into patterns and themes.[68] This approach to analysis allowed the evaluator to make sense of the data collectively as well as individually. Notes and recordings from the focus groups and interviews were manually coded by evaluator. The evaluator pored over the detailed notes and revisited the recordings to identify relationships among the codes. The evaluator took caution to not make hasty generalizations that could be unwarranted and not aligned with the data. Data from the individual interviews and focus groups provided mutually supported findings. The focus group data offered a breadth of information and the interviews aided with depth.

The local evaluator was the only person to review the data. Members of the evaluation committee were not available to aid in the thematic analysis; thus, interrater reliability is limited. However, member checking with the evaluation committee was completed to ensure that all interpretations were reasonable and appropriate.

Descriptive statistics utilizing univariate analyses (frequencies) were applied to analyze all data utilizing analysis features in the Qualtrics platform. The pre- and post-test data were reviewed individually and together to find patterns. Descriptive statistics aided in understanding changes in knowledge of Islamic cultural and spiritual practices and peer support concepts and attitudes after receiving training.

The mixed method analysis involved combining the data for meaningful interpretation. This was accomplished by identifying mutually supported findings to address the research questions. Analysis was conducted twice during each cycle and then taken together to provide an overview of the overall project findings. A process of validation was undertaken to verify the qualitative and quantitative data and in providing a complete pictures of PSS knowledge and attitudes; thus, producing a more robust analysis of the phenomena.

Key in the validation process was member checking with participants. Member checking is a process for checking back with participants to ensure that their perspectives are represented as they meant them and not as the evaluator views them. This step in the evaluation process was critically important as it aligns with the CBPR orientation of this evaluation. The CBPR paradigm values the primacy of practical and local knowledge.[69] In this instance, it is the participants themselves as well as the MAS-SSF staff, board members, evaluation committee, and community. Additionally, the evaluator shared preliminary findings and assumptions with members of the evaluation committee and MAS-SSF staff to fully understand cultural nuances that might not be easily explained or understood with additional background.

Results

Study Participants

The socio-demographic characteristics of the participants in this study are presented in Table 3. All participants were adults with 79.92% of participants were women and most participants were from Afghanistan, Iraq, and the U.S. Study participants are bilingual with many speaking two or more languages.

MAS-SSF Peer Support Specialist Demographics		
Gender	%	Count
Male	23.08%	6
Female	76.92%	20
Non-binary / third gender	0.00%	0
Prefer not to say	0.00%	0
Age	%	Count
18-25	6.85%	2
26-34	23.08%	6
35-54	54.69%	14
55-64	15.38%	4
65+	0.00%	0
Country of Origin	%	Count
Algeria	7.69%	2
Afghanistan	26.92%	7
India	7.69%	2
Iraq	19.23%	5
Egypt	3.85%	1
Pakistan	7.69%	2
United States	19.23%	5
Other	7.69%	2
Education		
High School Diploma or equivalent	0.00%	0
Some College	19.23%	5
Associate Degree	0.00%	0
Bachelor's Degree	34.62%	9
Master's Degree	15.38%	4
Professional Doctorate	7.69%	2

``Not Listed	23.08%	6
Language(s) Spoken (outside of English)*	%	Count
Arabic	25.64%	10
Dari	17.95%	7
Pashto	12.82%	5
Urdu	10.26%	4
Hindi	7.69%	3
Punjabi	7.69%	3
Other	17.95%	7

**Note: Frequencies may not equal 26 and percentages may not equal 100% due to multiple responses and statistical rounding*
Table 3: Cycle 1 and Cycle 2 Participant Characteristic Frequencies

Qualitative Data Findings

Findings of the qualitative strand are reported according to the corresponding evaluation question.

Evaluation Question 1: What prior knowledge, experiences do Peer Support Specialists have, as it pertains to peer support, prior to training?

Data from applicant screening, focus groups, and interviews were utilized to arrive at an answer for this evaluation question. PSS came into the program with lived experience, professional experience, and educational experience. Each PSS reported bringing lived experience of hardship (e.g., acculturative stress, family challenges, Muslim community stigma of mental challenges, etc.) and mental health challenges. When asked why they decided to become a PSS, most reported their desire to support other people experiencing similar challenges.

> "*Life experience made me want to get involved especially after going through my own mental health challenges and growing up family members with mental health challenges. Peer support was introduced to me after experiencing post-partum depression. While going through post-partum depression, there were unmentionable thoughts. When I decided to speak that truth, I got confirmation of 'me too'. I had great experiences with other moms, and we were each other's peer support. Slowly we started helping each*

other out. We started seeking out programs at mosques that were informal support groups. I saw how people flourished and I want to be in mental health. I prayed for an opening and a few weeks later the peer support training came my way." – Cycle 1 Peer Support Specialist

"I want to give back to community through mental health. I recently became acquainted with its importance through my own life and realization of the lack of support."
-Cycle 2 Peer Support Specialist

"I wanted to know all of the resources available for people to get help or for myself. It is really taboo topic in our culture, so I wanted to know more and find resources and places to directly connect people when they need it." --Cycle 2 Peer Support Specialist

"I got interested in this because I have a life experience with someone I loved who had mental health challenges. My experience with the community and the system that wasn't helping a lot. I struggled my own and was familiar with MAS-SSF and the work they do in the community. In 2007, started with MAS-SSF to receive help. Once built confidence in myself, I wanted to work with others"
- Cycle 1 Peer Support Specialist

"My passion is working with individuals 1-on-1. From working with people doing volunteer work, I understand that each person has a challenge through life. When the opportunity came up to become a peer specialist, I took the opportunity to learn more."
- Cycle 1 Peer Support Specialist

PSS professional experience expands from work before they migrated to the U.S. and their current occupations working with the Muslim community. Among the PSS are case managers, a women's health counselor, social workers, and nonprofit employees. One PSS is a case manager for Muslim transitional house while another has been a counselor for 25 years. Some PSS spoke to wanting to become a PSS to enhance the work they do already.

"I came across a lot of women who come in the shelter [at place of employment] that are only comfortable with me. I wanted to get certified to become a peer counselor to make sure I am doing the right thing."
- Cycle 1 Peer Support Specialist

Most PSS have some college experience; 34.62% have bachelor's degrees, 15% have master's degrees, and 7% have a professional degree or doctorate.

> *"I had a background in psychology; a master's degree from my country. I love that this is an extension of my work and training."* - Cycle 1 Peer Support Specialist
>
> *"I love to talk to people and listen to them. I was doing a PhD in clinical psychology in Pakistan then I moved to the U.S. I was busy with family but wanted to do something and then I found MAS-SSF."* - Cycle 1 Peer Support Specialist
>
> *"My background is in clinical psychology. I have lived experienced with family members with mental health problems, and I have a passion of helping others. I wanted to get information on how to cope and help to other people. Women are not helped a lot and it is not understood. As a refugee, I didn't know all of the resources so becoming a peer counselor has helped me with knowing the resources and supporting other women."* - Cycle 1 Peer Support Specialist

Evaluation Question 2: What characteristics or attributes do Peer Support Specialists have in common?

Data from applicant screening, focus groups, and interviews were utilized to arrive at an answer for this evaluation question. The PSS mentioned their lived experience led them to engaging with *Shifa for Today*. Many of their careers in the so-called "helping professions" or career fields like medicine, social work, public health, human services, and mental health. The most similar attribute across all PSS were their desire to "walk with others" through their experiences with hardship and emotional challenges. Several mentioned the feelings they experienced when they were new to the U.S. and when they experience hardship and that they felt alone. Knowing that feeling spurred their desire to help. Although the PSS carry similar attributes, the nature of their lived experiences varied greatly. Some PSS had acculturation stress, some dealt with deaths in their family, and others experienced the loss of their former identities such as previous profession (i.e., doctor or engineer in home country) or as a pillar in their community.

Evaluation Question 3: What feedback do Peer Support Specialists offer following training?

Data from focus groups and interviews were utilized to arrive at an answer for this evaluation question. PSS offered a great deal of feedback regarding their training. Most PSSs acknowledged their appreciation of the facilitator, Lisa St. George. They found Mrs. St. George to be knowledgeable, empathetic, and a role model of the types of qualities of a peer support specialist. A cycle 1 PSS said, "Lisa is incredible. She is very patient and humble. She gave us the platform to add in more knowledge. She was instructing and learning. She let everyone express themselves the way the wanted."

The PSS reported learning how to support others through the training. Skills for supporting others included validation, actively listening, nonjudgmental communication, being cognizant of culture, and spiritual and religious practices. PSS emphasized learning a significant amount about active listening and not forcing their opinions or perspectives on the clients. They learned through training that it was not their position to provide answers or advice to their clients' challenges, but to help them—through empowerment—arrive at conclusions.

> *"The training gave me the answer of how to connect the bridges between their former life and their life here. The beginning is the hardest part to adjust to and figure out how much you take from the former culture and how much you give up. I am so happy I took this class because I have the fundamentals of communication and delivering."*
> - Cycle 1 Peer Support Specialist

PSS reported appreciating the training and how it aided in open mindednesses. They described the open mindedness as seeing beyond their own lives and perspectives and learning how to see others. The dialogue with peers in the training was also supportive of this.

> *"I have never worked outside of the home. This training allowed me to go outside and open my mind. I always think how I can help the community and help others."* - Cycle 1 Peer Support Specialist

> *"Hearing other people's experiences was helpful. You go into a training knowing that people have different experiences but hearing firsthand experiences is helpful. Learning how to be present and there for people is great and getting the tools on how to do that. I*

learned how to put aside my own biases and how to uncover my own biases. The class taught us to put the religion aside for a moment and see the person." - Cycle 1 Peer Support Specialist

The message I got from training is that everybody can use support. We all have different challenges and some of us might not realize that we treat people without consideration of the challenges. Lisa was amazing. The experience that opened my eyes during training was each person's experience and how they overcame something. - Cycle 1 Peer Support Specialist

"I learned the difference between sympathy and empathy (when you empathize with people it comes from the heart instead of saying how sorry you are). I learned about the importance of the love and time spent with others. We were taught to listen, observe, and understand." - Cycle 1 Peer Support Specialist

"I learned a lot about people from different cultures and how to be sympathetic to people from different backgrounds. We learned the dos and don'ts of the religion in terms of counseling. Learned how to be a better Muslim and counselor. - Cycle 1 Peer Support Specialist

The training also provided PSS with concrete tools for supporting healing in others. They recalled learning how to validate others through listening. The training helped untangle the differences between culture and religion. Religion is the most important aspect in healing, and they learned how to use (Islamic practices) to help and not hurt. They were taught not to make Islamic interpretations but provided the tools to guide the client to the right resources.

"I learned a lot of things. I learned how to take care of a case, how to listen, how to react, and how to deal with people. If someone has a difficult time, I can give a surah to help them." - Cycle 1 Peer Support Specialist

"When somebody needs help, and they want us to learn the spiritual point-of-view and tell them it is not their fault and that they are strong enough to face their problem." Cycle 1 Peer Support Specialist

"Very spiritually uplifting to realize how much peer counseling is based in the Quran." Cycle 1 Peer Support Specialist

Moreover, they were taught how to learn culture, respect the culture, frame situations, and give people a safe place to talk.

"I spent a lot of time on the person we are working with, managing when they react (e.g., discomfort, acting up) and we respond with a calm, cool head. We also discussed not getting too personal, no touching, suicide assessment, what to do if something has escalated (not jump the gun and dial 911 and how our own actions shouldn't escalate the issue), and if a person is agitated." - Cycle 2 Peer Support Specialist

When asked if they would be comfortable taking a case, PSS were split in their level of comfort. PSS with previous experience and more time as a PSS were more confident in taking cases. The lack of confidence stemmed from having the formal knowledge from training but lacking the hands-on experience with documenting/notetaking and role playing.

"I comfortable starting the case, but I do not know how to document. I need examples." --Cycle 2 Peer Support Specialist

"I would have liked training to be more interactive. There was extremely beneficial theory but more on the application was needed. Keep the information but balance that with breakout rooms and discussion driven scenarios." --Cycle 2 Peer Support Specialist

"I would take the case because I have all of the information, but I don't feel comfortable taking it independently. I would want a backup or a supervisor. If I were to talk to someone, I wouldn't know what to write…you know the small things. We were given a generalized example, but it was specific enough." --Cycle 2 Peer Support Specialist

"After watching the videos, I feel good but I don't know what to write and what to focus on." --Cycle 2 Peer Support Specialist

"This class was wonderful, and Lisa is fantastic. We didn't have enough time to do role play. Doing things independently is difficult; need someone to guide on how to document, etc." --Cycle 2 Peer Support Specialist

"No, I would need a little more support and training. I felt the training was very beneficial, but I need more in terms of role play or a few more case scenarios to build that confidence. Practical application, basically." --Cycle 2 Peer Support Specialist

"Depending on the case, I would be ready. I am rusty. I need to practice role playing and practice the language." --Cycle 2 Peer Support Specialist

"Not ready. I would like practice scenario or role play on how to share information with the client." --Cycle 2 Peer Support Specialist

"In addition to the role plays, the person conducting the training should tell us real life situations and what impact it had. This would boost our morale and give us hope. Lisa did give examples and that was wonderful." --Cycle 1 Peer Support Specialist

"Case review is really wonderful. We need more time for every scenario. It is too much pressure to solve a case in 10 minutes. We can do this is small groups. I feel like we are repeating things in the 4 modules. The Quran and Surrah are too much to digest in such a short amount of time." --Cycle 1 Peer Support Specialist

"Anytime we have a meeting we have a role play." --Cycle 1 Peer Support Specialist

Additional training or continuing education that focused on role playing and case reviews were suggestions made by PSS. PSS also suggested including more content about specific cultures. Cycle 2 PSS recommended modifying the training schedule to space the sessions out and reduce the length of time of each session. The 32-hour Cycle 2 training took place across four days for eight-hour sessions due to the COVID-19 pandemic and the need to complete training before a religious holiday.

Evaluation Question 4: What modifications are made to *Shifa for Today* training following first and second cycle?

Data from focus groups and interviews were utilized to arrive at an answer for this evaluation question. The preliminary finding of additional training focused on role playing and case reviews, more background on specific cultures, and modifying the training structure were shared with the subject matter expert and evaluation committee by the local evaluator. Material changes that have been made to the curriculum are the addition of role plays that have been added to each section. These changes were made after Cycle 2 in 2021. A tool will be shared with participants on which they will document as if they were providing the peer support in the role play (even if they were not) and document the goals, plans, and other aspects of documentation for each role play.

Evaluation Question 5: What type of peer support and community engagement are Peer Support Specialists engaged in?

Data from focus groups and interviews were utilized to arrive at an answer for this evaluation question. PSS are actively engaged in their community. In the recruitment and application phase, many noted the ways in which they are active in the Muslim community. Many are active through their engagement with MAS-SSF. For those involved with MAS-SSF, they recalled becoming acquainted with MAS-SSF and the program through word-of-mouth from a friend or family member or from being involved in the community.

> *"I started volunteering with MAS in 2018. I enrolled in the Shifa program in 2018. I have also been volunteering regularly with many other programs MAS-SSF has. I am so glad I have had the chance to volunteer with them, especially for our community. There are many issues with language, and this is an important service we are providing to the community."* --Cycle 1 Peer Support Specialist

> *"I've been volunteering since 2016 and I became a certified peer specialist in 2019."* --Cycle 1 Peer Support Specialist

> *"I joined MAS-SSF in 2016. I was in the first training group to become a peer specialist. Someone sent the invitation and he signed up because I really liked the idea of what they did."* --Cycle 1 Peer Support Specialist

> *"I am familiar with MAS-SSF because mom is very involved. Now my mom is involved in multiple projects and sits on the board. I want to give back to community through mental health because we don't talk about it enough and this is important"* --Cycle 2 Peer Support Specialist

> *"I've been with MAS-SSF since it started in May 2007 because of my background in masters in clinical psychology. I enjoy MAS-SSF and it is my second home. God gave me something and I am giving something back."* --Cycle 1 Peer Support Specialist

> *"I've been part of MAS-SSF for 15 to 20 years. I've been involved in Muslim community too. I learned about MAS-SSF from brother who is does stuff in MAS-SSF. I am attracted to the focus work on social services because our community needs that help."* --Cycle 1 Peer Support Specialist

For others engaged on their own, several PSS mentioned being active in their mosques, children's schools, and Muslim community volunteering. For most of the PSS, the involvement

is a combination of their own community work, MAS-SSF work, and their professional work that makes up their community involvement.

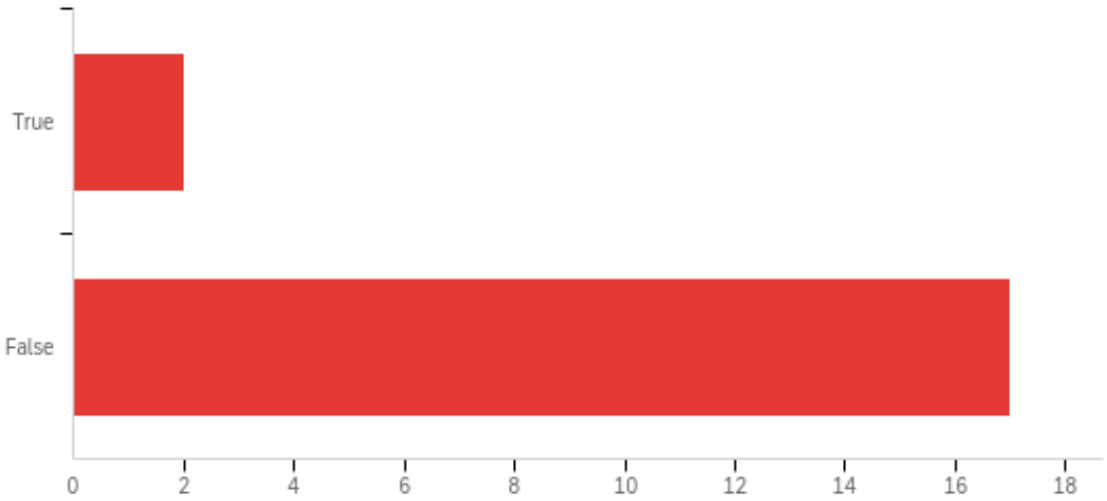
Quantitative Data Findings

Evaluation Question 4: What modifications are made to *Shifa for Today* training following first and second cycle?

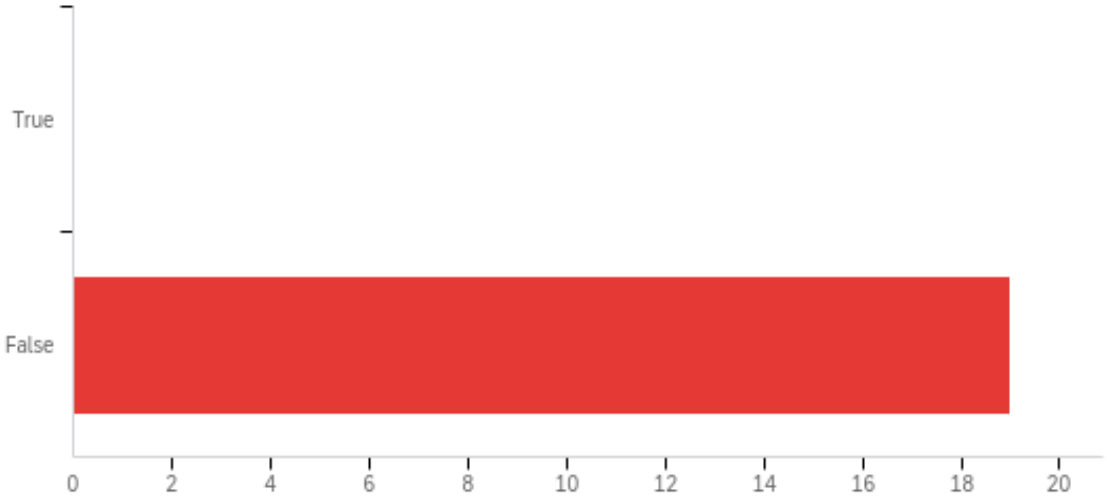
Data from the pre- and post-test assessment were utilized to answer the evaluation question. The Recovery Knowledge Inventory was administered after PSS participated in peer specialist certification, but before their *Shifa for Today* training. An examination of the data derived from the Recovery Knowledge Inventory [**see Appendix F**] demonstrated that PSS perspectives did not change before and after training. A plausible explanation for the lack in change by the PSS is that they had already been exposed to peer training through their certification course. Moreover, many came into the program with a basic foundational understanding of mental, recovery, and peer support.

The *Shifa for Today* pre- and post-test was an original assessment designed by the curriculum development consultant. Similarly, there were no significant changes in responses on the *Shifa for Today* assessment. PSS came in with significant knowledge about peer support in the cultural context. For example, questions 13 and 14.

> *Q13 - As trained Peer Support Counselors working as a Muslim oriented service provider, we have earned the right to tell people what they are doing wrong as Muslims and how they should fix it.*

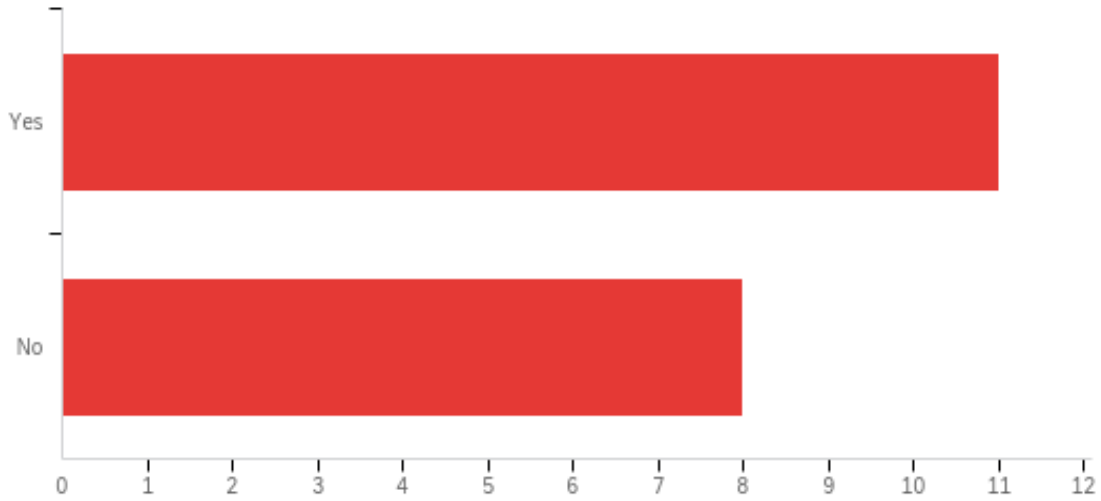


Q14 - The first thing to do when a person comes to us seeking support is to guide them to read Quran and pray more.



For both questions, most of the PSS were correct and did not deviate from that response following their training. Q20 varied the most in responses.

Q20 - If we are working with an individual as a Peer Support Counselor and they engage in behavior that we do not approve, are we able to request that we no longer work with that individual? Please explain your answer.



The answer to this question is 'yes'. The post-test data reflected that PSS understanding of their ability to make changes to their client assignments improved greatly.

Overall Presentation of Findings

The collection of prominent themes presented in this section was discovered through thematic analysis of data derived from focus groups, interviews, and pre- and post-test assessments.

Finding 1: Peer Support Specialists are driven to provide peer support out of an intrinsic need to support others

PSS overwhelmingly reported that they joined *Shifa for Today* program because of their desire to support others through hardship and challenging times.

Finding 2: Peer Support Specialists entered *Shifa for Today* with skill, education, and lived experience

PSS share similar characteristics in terms of skill, education, and lived experience. Most PSS come from careers in the "helping professions" or career fields like medicine, social work, public health, human services, and mental health. The most similar attribute across all PSSs were their desire to "walk with others" through their experiences with hardship and emotional challenges. PSS also share have some college experience; 34.62% have bachelor's degrees, 15% have

master's degrees, and 7% have a professional degree or doctorate. Moreover, PSSs reported lived experiences with mental health challenges.

Finding 3: *Shifa for Today* training curriculum and delivery provided valuable conceptual and theoretical tools for Peer Support Specialists

PSS gained valuable tools and resources from the *Shifa for Today* training. They were able to clearly articulate the concepts learned throughout training around actively listening, peer support, healing and recovery, ethics, and empowerment. The peer specialists also appreciated the facilitator of the training as they found her knowledgeable, compassionate, and a positive role model of peer support.

Finding 4: Peer Support Specialists lack sufficient hands-on, practical experiences in *Shifa for Today* training

Many PSS repeatedly reported that they felt they needed more hands-on, practical experiences to be truly prepared to take cases. There were opportunities in the formal *Shifa for Today* training for role play, but that was not sufficient. The PSS want more opportunities to practice and see real-life examples of cases. An opportunity to provide this hands-on training is in the monthly meeting with PSS where they engage in short learning discussions and role plays.

Discussion

Shifa for Today is an early intervention program focused on providing culturally tailored support to SAMs, with an emphasis on immigrants and refugees. This CDEP focused solely on the development of the volunteer PSS workforce who will provide the peer support. The findings of this evaluation provide valuable insights into recruitment and screening of volunteer peer specialists, curriculum development, and training.

Bright Spots

A clear bright spot of this project is having PSS with lived experience that will likely align with the client. Literature on peer support notes that it is not based in psychiatric or clinical models; instead, it centers on understanding another's situation through empathy, support, and a lens of a shared experience of emotional and psychological pain.[70] The PSS were candid about their personal experiences and challenges and their desire to "walk with others" through their own problems. The quality of fit of PSS indicates that MAS-SSF has done an exceptional job recruiting and cultivating relationships with volunteers who are willing to engage so deeply with others.

The PSS commitment to others reflect the potential benefits of volunteering and prosocial behavior. By nature, peer support is a form of volunteerism that requires work without an expectation of reward. Prosocial behavior is a term that refers to activities benefiting other people or society. These behaviors are usually divided into three categories: altruism, helping, and cooperation.[71] The benefits of volunteering for the volunteer are well-established. The literature on formal volunteering reflects significant benefits to the volunteer that include social inclusion, improved mental health, and overall wellness.[72,73] Reviewing and understanding the benefits of serving as a PSS should be a considered as an area of future evaluation.

The similar attributes across PSSs in profession, education, and lived experience reflect a more professionalized pool of volunteer PSSs. It is important to note that, although PSSs share similar attributes, the nature of their lived experiences varied widely. This range of experiences is likely to contribute to creating stronger matches between PSS skills and client needs. While there is no single description of what makes the best peer support, peer support is often wanted and most useful from "people like me".[74] A shared or similar lived experience is supportive in building out culturally tailored peer support programming to enhance outcomes and reduce unintended consequences and exacerbating challenges.

The delivery of a curriculum culturally tailored specifically for SAMs population appears to have been timely and relatable. The PSSs desired to have more training on culture. The difficulty of including more detail on culture is that there are so many cultures and nuances associated with each culture. Moreover, the intersecting identities that each unique client will have adds an additional layer of complexity.[75] Finding methods of infusing more cultural training into the curriculum and figuring out the correct balance for the training will be helpful in the future. Unfortunately, literature is scant on how to effectively and efficiently culturally tailor interventions and their influence on health outcomes.[76] Understanding how the culturally tailored curriculum from this project modifies patient outcomes will be an important area of evaluation.

The lack of hands-on experiential training was a deficit of this project. Essentially, experiential learning is learning by doing. Experiential education goes beyond learning by doing as it has been found to be emotionally engaging and transformative.[77,78,79] Time limitations played a role in the lack of experiential training. Creating more opportunities for experiential learning for PSS should be included in next iterations of training.

Future Implementations and Opportunities

This evaluation was a process evaluation. It assessed whether programs were implemented as intended and as well as the outputs of the programs. Moving forward, more outcomes-based measures will be appropriate for this project. Understanding more nuanced outcomes related to PSS training will be key to creating the correct balance of theoretical knowledge and time for practical application. The PSS spoke clearly about the need for practical application. More time for practical application has been added to future models and that will be to be assessed to understand if the scope and nature of the change has been effective.

PSS enthusiastically requested more training on different cultures. This project was specifically funded to train and serve the SAM population; however, Middle Eastern Arabic-speakers are among the largest population of Muslims. MAS-SSF is expanding its training to include cultural components for these populations. Moreover, a library of information is developed to house literature about various Muslim sub-cultures for PSS to explore on their own. Culture and the variations among cultures are vast and MAS-SSF will never to be able to address any one in substantial detail. The library will allow for the PSS to explore the cultures they are most interested in learning about.

A disappointment throughout the project is the low number of cases. Stigma around mental health support is significant in this community. MAS-SSF is a visible and trusted member of the Sacramento County Muslim community. MAS-SSF continues performing community engagement activities outside of Shifa for Today to grow engagement and reduce stigma. For example, MAS-SSF is creating a youth component of *Shifa for Today* for youth ages 16 to 24 to increase interest in careers in mental health, grow the Muslim peer support workforce, and reduce stigma. Additionally, MAS-SSF is collaborating with Sacramento County officials to

expand outreach and engagement around COVID-19 vaccines to help immigrants and refugees get vaccinated. It is expected that these efforts can translate into more cases.

Conclusion

Shifa for Today reflects the intricacies of developing a culturally tailored peer support program for SAMs. PSS working with MAS-SSF are working from a higher purpose of spiritual caring. Having valuable PSSs, a well-developed curriculum, and an engaging training aid in building a peer support program that is poised to improve health outcomes and reduce disparities. The findings from this evaluation illuminate valuable insights to consider as MAS-SSF continues to grow *Shifa for Today*.

Appendices

Appendix A – Peer Support Specialist Sample Application and Screening Protocol

Demographics

1. First Name:
2. Last Name:
3. Year of birth (or age):
4. E-mail Address:
5. Phone Number:
6. Zip Code:

1. Highest level of education attainment [dropdown list]:
some high school; high school diploma or GED; some college; bachelor's degree; master's degree; doctorate

2. Do you have a criminal background? If so, please explain.:

3. Languages spoken [dropdown list of languages]:
   First:
      Branching Logic: reading, writing, and speaking
   Second:
      Branching Logic: reading, writing, and speaking
   Third:
      Branching Logic: reading, writing, and speaking

4. Dropdown List of languages:
   - Arabic (North African, Hassaniya, Egyptian, Levantine, Iraqi, Gulf, Hejazi, Najdi, & Yemeni)
   - Urdu (Dakhini, Pinjari, Rekhta, & Modern Vernacular Urdu)
   - Hindi (Braj Bhasha, Khari boli, Haryanvi, Bundeli, Awadhi, Bagheli Kannauji, & Chhattisgarhi)
   - Afghan (Pashto & Dari)
   - Hindi-Urdu (Punjabi)
   - Other (please specify):

5. Gender:
6. Country of origin:

Screening Questions

1. Why are you interested in becoming a peer counselor?
2. Have you served as a peer counselor before?
3. What is your current involvement in the Muslim community?
4. What is your lived experience with mental or emotional distress (e.g., depression, anxiety, bipolar disorder, etc.)?

5. Has there ever been a time you or someone you know has been in a crisis where you thought counseling might help?
6. Are you comfortable with working with the following groups?
    1. Men
    2. Women
    3. Lesbian, gay, transgender, or queer individuals
    4. People from different countries

Situational Questions

1. Your friend has shared that she is unhappy in her relationship with your husband. She shares with you that she is considering divorce. Please describe in detail of how you would respond to her.

Appendix B- Core Practices Focus Group Protocol

1. Why have you decided to become a peer counselor?
2. You participated in extensive training over the last four weeks. Tell me about what you learned?
3. What would you want to know more about (when it comes to peer counseling)?
4. If there was a case available tomorrow, how comfortable would you be with providing peer support? Why or why not?
5. What is one thing you would change about the training?
6. What final thoughts to do you have to share?

Appendix C – Closeout Focus Group

For Peer Support Specialists who have taken cases

1. Describe how long you have been with MAS-SSF?
2. Tell me about your experience taking cases?
3. Tell me what are key principles you learned from your Shifa for Today training?
4. What challenges have you experienced?
5. What additional information would be helpful to you?

For Peer Support Specialists who have not taken cases

1. Describe how long you have been with MAS-SSF and your feelings about the org?
2. What are doing to remain prepared for cases?
3. How do you feel you are contributing to your community?
4. How do you see your peer specialist training contributing to your future?
5. Have you had any personal changes since you went through changes?
6. Have you experienced any challenges with regard to being a peer specialist?

Appendix D – Recovery Knowledge Inventory Pre- and Post-Test

Date: _____ Code: _____

RECOVERY KNOWLEDGE INVENTORY

What is your understanding of the recovery process? Please rate the following items using the scale below:

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

1.	The concept of recovery is equally relevant to all phases of treatment.	1	2	3	4	5
2.	People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.	1	2	3	4	5
3.	All professionals should encourage clients to take risks in the pursuit of recovery.	1	2	3	4	5
4.	Symptom management is the first step towards recovery from mental illness/substance abuse.	1	2	3	4	5
5.	Not everyone is capable of actively participating in the recovery process.	1	2	3	4	5
6.	People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life.	1	2	3	4	5
7.	Recovery in serious mental illness/substance abuse is achieved by following a prescribed set of procedures.	1	2	3	4	5
8.	The pursuit of hobbies and leisure activities is important for recovery.	1	2	3	4	5
9.	It is the responsibility of professionals to protect their clients against possible failures and disappointments.	1	2	3	4	5
10.	Only people who are clinically stable should be involved in making decisions about their care.	1	2	3	4	5
11.	Recovery is not as relevant for those who are actively psychotic or abusing substances.	1	2	3	4	5
12.	Defining who one is, apart from his/her illness/condition, is an essential component of recovery.	1	2	3	4	5
13.	It is often harmful to have too high of expectations for clients.	1	2	3	4	5
14.	There is little that professionals can do to help a person recover if he/she is not ready to accept his/her illness/condition or need for treatment.	1	2	3	4	5
15.	Recovery is characterized by a person making gradual steps forward without major steps back.	1	2	3	4	5
16.	Symptom reduction is an essential component of recovery.	1	2	3	4	5
17.	Expectations and hope for recovery should be adjusted according to the severity of a person's illness/condition.	1	2	3	4	5
18.	The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment.	1	2	3	4	5
19.	The more a person complies with treatment, the more likely he/she is to recover.	1	2	3	4	5
20.	Other people who have a serious mental illness or are recovering from substance abuse can be as instrumental to a person's recovery as mental health professionals.	1	2	3	4	5

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Appendix E – *Shifa for Today* Pre- and Post-Test

Shifa for Today

1. When working with a person in my role as a peer support counselor using Shifa for Today, viewing each of us as having wisdom and knowledge is an important part of mutuality.

☐ **True** ☐ **False**

2. By studying in this Shifa for Today course, I now understand that I am required tell people what they should do from a spiritual perspective if they want a happy life. ☐ **True** ☐ **False**

3. People from Southeast Asia may be in the United States as refugees. Refugees are (choose one):

a) People fleeing famine, war, and homelessness.

b) People fleeing their home country because of a well-founded fear of persecution based on religion, nationality, race, political opinion, or membership in a particular social group.

c) People fleeing one city to get to a safer city in the same country due to well-founded fear of persecution based on religion, nationality, race, political opinion, or membership in a particular social group.

d) People fleeing famine, war, and homelessness in a country besides their own.

4. In Islam, there is one school of thought and everyone agrees with it. ☐ **True** ☐ **False**

5. If an individual asked for specific Islamic guidance on diversity and race relations, a peer counselor would be able to show the individual at least one surah that speaks to specific guidance from Allah that we are made differently and as Muslims we are guided to embrace our differences because Allah created us to be different. ☐ **True** ☐ **False**

6. Peer Support Counselors can engage in deeper relationships with the individuals they serve beyond their professional relationship. ☐ **True** ☐ **False**

7. When faced with an ethical dilemma, the first thing a peer support counselor should do is (choose one)

a) Seek guidance from a co-worker on what to do.

b) Study the dilemma on-line and find a solution.

c) Go to their supervisor and seek assistance.

d) Both A and C

8. Islamic manners require Muslims to

a) Embody the characteristics of the Prophet Muhammad

b) Engage in honest relationships with the people we serve outside of the peer support relationship.

c) Behave in honest, kind, and helpful relationships with the people we serve as a peer supporter.

d) Eat with people whenever we meet.

e) both A and C

d) both A and B

9. As a peer supporter, it is my responsibility to protect the people I serve from making mistakes. ☐ **True** ☐ **False**

10. When a person has a mental illness, they should not be burdened with the responsibilities of life.

☐ **True** ☐ **False**

11. Trauma Informed Care calls upon us to ensure we follow six specific principles to ensure the wellbeing of those we serve. Please name two of the principles _____ and _____

12. The first thing to do when a person comes to us seeking support is to guide them to read Quran and pray more. ☐ **True** ☐ **False**

13. When Peer Counselors work with someone,

a) They mustn't document to protect confidentiality

b) They need to write down everything that is said and share what the community needs to know

c) They get to choose if they want to work with that person or not

d) They must write clear documentation and keep confidentiality

14. As trained Peer Support Counselors working in a Muslim oriented service provider, we have earned the right to tell people what they are doing wrong as Muslims and how they should fix it. ☐ **True** ☐ **False**

15. If an individual asks for help with distress from an Islamic perspective, what are two things the Peer Support Counselor might offer to assist? _____ & _____

16. Malak talks about his experiences as a refugee. He says, "We ran from our home in the middle of the night. We could take nothing with us. Everything we owned was left behind. We ran for hours, and when we finally stopped, we were so hungry. We had no food with us. My brother and I stole some food from a stall in the marketplace. We ran away with it and my mother and father made us some soup with it using water from a well near where we were hiding. I just remember being hungry every day for months. Now, I just want to eat everything all the time, it is like I can't stop. It is becoming a big problem for me, because I always have to have food with me, or I can't do what I need to do at work or anywhere."

    What kind of an experience shows up in Malak's story?

    _____

17. Please write a response to Fatima that demonstrates **that you see strengths** in her.

    Fatima says, "I am exhausted. My son has been sick and in and out of the hospital since we arrived here to the United States. My husband says he caught a chill and can't get over it. I think that is right. We spent our last two days in Greece, waiting in the line to get our tickets to the United States. It was raining all day, both days and we did not have proper coats and hats and our feet got wet. My son was shivering. I kept him warm by giving him my coat, but I don't think it helped much. Anyway, I have been staying in the hospital with my son, sleeping in a chair, and I wonder what I am doing wrong that he can't get better?

    _____
    _____
    _____
    _____
    _____
    _____

18. In South Asian culture, everyone has the same belief system and practices, they are all alike. ☐ **True** ☐ **False**

19. An event occurred when England exited the Indian Sub-Continent which displaced millions of people. What was this event?

    _____

20. If we are working with an individual as a Peer Support Counselor and they engage in behavior that we do not approve, are we able to request that we no longer work with that individual? ☐ **Yes** ☐ **No**

    Please explain your answer.

    _____
    _____
    _____

_____
_____
_____

Appendix F – Recovery Knowledge Inventory Pre- and Post-Test Descriptives

Recovery Knowledge Inventory Pre-Test							
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	The concept of recovery is equally relevant to all phases of treatment.	1.00	5.00	4.53	1.14	1.31	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
2	People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.	1.00	5.00	2.53	1.50	2.25	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
3	All professionals should encourage clients to take risks in the pursuit of recovery.	1.00	5.00	3.06	1.39	1.94	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
4	Symptom management is the first step towards recovery from mental illness/substance abuse.	1.00	5.00	3.53	1.38	1.90	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
5	Not everyone is capable of actively participating in the recovery process.	1.00	5.00	2.47	1.61	2.60	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
6	People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life.	1.00	5.00	2.00	1.24	1.53	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
7	Recovery in serious mental illness/substance abuse is achieved by following a prescribed set of procedures.	1.00	5.00	3.06	1.63	2.64	17

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
8	The pursuit of hobbies and leisure activities is important for recovery.	1.00	5.00	4.24	1.16	1.36	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
9	It is the responsibility of professionals to protect their clients against possible failures and disappointments.	1.00	5.00	2.29	1.67	2.80	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
10	Only people who are clinically stable should be involved in making decisions about their care.	1.00	4.00	1.71	0.96	0.91	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
11	Recovery is not as relevant for those who are actively psychotic or abusing substances.	1.00	2.00	1.06	0.24	0.06	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
12	Defining who one is, apart from his/her illness/condition, is an essential component of recovery.	1.00	5.00	3.29	1.77	3.15	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
13	It is often harmful to have too high of expectations for clients.	1.00	5.00	2.94	1.59	2.53	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
14	There is little that professionals can do to help a person recover if he/she is not ready to accept his/her illness/condition or need for treatment.	1.00	7.00	4.94	1.89	3.58	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
15	Recovery is characterized by a person making gradual steps forward without major steps back.	1.00	5.00	3.76	1.39	1.94	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count

16	Symptom reduction is an essential component of recovery.	1.00	5.00	3.82	1.34	1.79	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
17	Expectations and hope for recovery should be adjusted according to the severity of a person's illness/condition.	1.00	5.00	3.53	1.72	2.96	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
18	The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment.	1.00	5.00	3.12	1.64	2.69	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
19	The more a person complies with treatment, the more likely he/she is to recover.	2.00	5.00	4.35	0.97	0.93	17
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
20	Other people who have a serious mental illness or are recovering from substance abuse can be as instrumental to a person's recovery as mental health professionals.	1.00	5.00	4.12	1.08	1.16	17

Recovery Knowledge Inventory Post-Test							
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	The concept of recovery is equally relevant to all phases of treatment.	1.00	5.00	4.42	1.27	1.61	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
2	People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.	1.00	5.00	1.58	0.99	0.98	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
3	All professionals should encourage clients to take	1.00	5.00	3.26	1.65	2.72	19

	risks in the pursuit of recovery.						
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
4	Symptom management is the first step towards recovery from mental illness/substance abuse.	1.00	5.00	3.53	1.46	2.14	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
5	Not everyone is capable of actively participating in the recovery process.	1.00	5.00	2.28	1.52	2.31	18
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
6	People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life.	1.00	5.00	1.63	1.22	1.50	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
7	Recovery in serious mental illness/substance abuse is achieved by following a prescribed set of procedures.	1.00	5.00	2.78	1.69	2.84	18
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
8	The pursuit of hobbies and leisure activities is important for recovery.	4.00	5.00	4.74	0.44	0.19	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
9	It is the responsibility of professionals to protect their clients against possible failures and disappointments.	1.00	5.00	1.95	1.43	2.05	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
10	Only people who are clinically stable should be involved in making decisions about their care.	1.00	5.00	1.74	1.25	1.56	19

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
11	Recovery is not as relevant for those who are actively psychotic or abusing substances.	1.00	5.00	1.56	1.30	1.69	18
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
12	Defining who one is, apart from his/her illness/condition, is an essential component of recovery.	1.00	5.00	3.89	1.63	2.65	18
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
13	It is often harmful to have too high of expectations for clients.	1.00	5.00	3.67	1.49	2.22	18
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
14	There is little that professionals can do to help a person recover if he/she is not ready to accept his/her illness/condition or need for treatment.	1.00	7.00	5.16	1.90	3.61	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
15	Recovery is characterized by a person making gradual steps forward without major steps back.	1.00	5.00	3.37	1.66	2.76	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
16	Symptom reduction is an essential component of recovery.	1.00	5.00	4.11	1.41	1.99	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
17	Expectations and hope for recovery should be adjusted according to the severity of a person's illness/condition.	1.00	5.00	3.32	1.72	2.95	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count

18	The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment.	1.00	5.00	2.74	1.74	3.04	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
19	The more a person complies with treatment, the more likely he/she is to recover.	2.00	5.00	4.37	0.74	0.55	19
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
20	Other people who have a serious mental illness or are recovering from substance abuse can be as instrumental to a person's recovery as mental health professionals.	3.00	5.00	4.37	0.87	0.76	19

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