Recovery International

Recovery International Group Meeting Evaluation Executive Summary

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This Executive Summary is dedicated to Kathy Garcia. Kathy believed in RI, this evaluation, and the importance of empirically documenting the benefits of RI participation. Without her, this evaluation would not have been conducted. Although she is no longer with us in body, she is with us in spirit. Peace to her memory.

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Introduction

RI is a renown, cognitive-behavioral, peer-to-peer self-help training system. With groups meeting weekly, it is perhaps one of the largest peer-led programs for persons struggling with emotional and mental health problems. Although hundreds of thousands of people have used the RI Method, not much is known about the reasons why individuals initially decide to go to RI meetings, and why some decide to stop attending meetings. Additionally, little research has examined how participation in group meetings helps individuals better manage their everyday problems.

To address this knowledge gap, the RI Group Meeting Evaluation had two goals: (1) collect information on RI group participation and satisfaction; and (2) examine the extent to which RI participation helps individuals cope with daily life challenges. These combined data are important scientific evidence ALSHS needs to document RI participation benefits to policy makers and program administrators who make decisions about what services to offer to people living with serious emotional problems.

This Executive Summary provides a basic overview of the evaluation. Major findings regarding RI participation, satisfaction and benefits are described in this document. The final report discusses our results in greater detail, and will be available in March 2011.

Recruitment and Enrollment Procedures

Although many RI participants have attended groups for several years, and have much to share with us about how RI has helped them, our evaluation focused on newcomers. We chose newcomers—individuals who have attended five or fewer RI meetings—in order to better understand the reasons why someone initially decides to go to RI; the factors involved in why they continue to go to groups (or stop going to groups); and when participation benefits may first occur. We can think of this process as being akin to a drug study: in order to see if a drug works, we want to test it on someone who has never had the drug before.

Our original goal was to enroll 120 newcomers in the evaluation. When we began the evaluation in 2008, we initially focused on RI Areas that had several large groups meeting on a regular basis, such as California and Michigan. However, initial enrollment was much slower than we anticipated, so, together with ALSHS, we invited all RI group leaders nationwide to take part in the evaluation.

A total of 97 group leaders joined us in the evaluation. Each of these group leaders participated in mandatory conference calls led by Dr. Pickett. During these calls, they learned participant recruitment procedures, reviewed recruitment materials, and discussed specific scenarios (for example, what to do if someone who wasn't a newcomer wanted to be in the evaluation). Group leaders then received a shipment from UIC that contained flyers and evaluation introduction packets. The flyer listed basic information about the evaluation and the 800# for newcomers to call if they were interested in being in the study. The evaluation introduction packets contained a welcome letter from Dr. Pickett, a 2-page fact sheet, and a flyer. During Mutual Aid, group leaders gave evaluation introduction packets to newcomers. Group leaders read a short script prepared by Dr. Pickett that was approved by the UIC Institutional Review Board (IRB)[1] .The script explained that RI was doing an evaluation, and instructed newcomers to read their packet materials and call the number on the flyer if they were interested in being in the study. Since some newcomers might leave before Mutual Aid, we asked group leaders to make flyers available at the beginning of meetings so that everyone would have some information about the evaluation.

Newcomers who were interested in participating in the evaluation called the project's toll-free 800# number. UIC evaluation staff screened all callers for eligibility. In order to be in the evaluation, individuals were required to be: (1) age 18 years or older; (2) be an RI newcomer; (3) express interest in the study; and (4) provide informed consent. UIC evaluation staff also explained all study procedures to these callers, and answered their questions. Callers who met eligibility criteria and who agreed over the phone to be in the evaluation were sent a consent form packet. UIC evaluation staff instructed callers to read and sign the consent form, and use the self-addressed

[1] The UIC IRB oversees all research conducted by UIC faculty and staff, and ensures that studies meet federal regulations designed to protect participants' confidentiality and safety. Before we could begin our RI evaluation, we were required to obtain UIC IRB approval. We obtained this approval in June 2008.

stamped envelope to return the signed consent form to us. No newcomers were officially enrolled in the evaluation until we received their signed consent documents.

A total of 126 newcomers nationwide enrolled in the evaluation. All newcomers were asked to tell us the city and state where they were attending RI groups. As shown in Table 1, the majority of evaluation participants were attending groups in California. Note: This table does not list all of the states in which we had RI group leaders distributing evaluation materials. It was up to newcomers—not group leaders—to decide whether to call and enroll in the evaluation. RI groups in some states, such as Iowa, participated in the project, but no newcomers from any RI groups in Iowa chose to call us and enroll in the evaluation.

Table 1: Evaluation Enrollment by State (N=126)		
State	N	%
California	N=57	(45%)
Ohio	N=20	(16%)
Oregon	N=11	(9%)
New Jersey	N= 8	(6%)
Pennsylvania	N= 6	(5%)
Illinois	N= 5	(4%)
Michigan	N= 5	(4%)
Florida	N= 4	(3%)
Minnesota	N= 3	(2%)
New York	N= 3	(2%)
Georgia	N= 1	(.5%)
Texas	N= 1	(.5%)
Utah	N= 1	(.5%)
Washington	N= 1	(.5%)

Interview Procedures

Evaluation participants were asked to do four telephone interviews. Each interview was conducted by a UIC evaluation team member. The first interview—also referred to as the baseline interview or Time 1—was conducted within 2-4 weeks after newcomers enrolled in the evaluation. We could not and did not do any interviews with participants until *after* we received their signed consent document. The second interview—Time 2—was conducted 3 months after the first baseline interview. Time 3 interviews were conducted 6 months post-baseline, and Time 4 interviews were conducted 12 months post-baseline.

Each interview was an hour long, and done at a time that was convenient for participants. During each interview, we asked participants about their participation in RI (whether and why they were attending group meetings); satisfaction with RI; RI knowledge; mental health symptoms; personal recovery; feelings of empowerment,

hope, and emotional well-being; social support; self-stigma; and their use and need of mental health and social services. Participants received a $15 money order for each interview they completed.

Of the 126 newcomers who enrolled in the evaluation, two individuals were found to be ineligible and were removed from the study before we did their Time 1 interviews. Another five participants told us that they had changed their minds, and withdrew from the evaluation shortly after they enrolled. Of the remaining 119 participants, 114 (96%) completed Time 1 interviews. Eight of these individuals dropped out of the study before their Time 2 interview (some told us that they change their minds and didn't want to be in the study; others told us that they weren't going to RI anymore and didn't want to do anymore interviews). This left us with a sample of 106 participants; 95 (91%) completed Time 2 interviews and 83 (76%) completed Time 3 interviews. One more person withdrew prior to his/her Time 4 interview. Of the 105 participants eligible to complete Time 4 interviews, 79 (75%) completed Time 4 interviews. These are very good follow-up rates for longitudinal studies that where interviews are all done by telephone. The final report will describe in detail the many things we did to locate participants for their follow-up interviews.

Who Participated in the RI Evaluation?

We collected demographic information (age, gender, race, etc.) from participants during their Time 1 interview. As shown in Table 2, most of the evaluation participants were female (74%) and Caucasian (86%). Participants ranged in age from 25 to 73 years, and had an average age of 50 years. On average, participants attended 15 years of school (high school + 3 years of college). Most (66%) earned $20,000 per year or less. Slightly less than a third of participants (27%) were married. The majority of participants lived in their own home or apartment (85%). Only 34% of participants were employed.

Table 2: Participant Demographic Characteristics (N=114)

Participant Characteristics		N	%
Gender			
	Male	30	26%
	Female	84	74%
Race			
	African American	7	6%
	Asian American	1	1%
	Caucasian	97	86%
	Native American	1	1%
	Other	7	6%
Ethnicity			
	Hispanic/Latino	10	9%
	Not Hispanic/Latino	104	91%
Age, in years (range, mean)		25-73	50
Education, in years (range, mean)		10-22	15

Table 2: Participant Demographic Characteristics (N=114) Participant Characteristics		N	%
Income			
	Less than $10,000 per year	30	27%
	$10,000 to $20,000 per year	33	30%
	$20,000 to $30,000 per year	13	12%
	$30,000 to $40,000 per year	8	7%
	$40,000 to $50,000 per year	7	7%
	More than $50,000 per year	19	17%
Marital Status			
	Married	30	27%
	Living as married	1	1%
	Divorced	39	34%
	Separated	3	3%
	Never been married	40	35%
Residential Status			
	Own apartment or house	97	85%
	Lives with family other than significant other	11	10%
	A friend's house or apartment	2	2%
	Housing provided by a service provider agency	1	1%
	Hospital or alcohol/drug treatment program	2	2%
Employment Status			
	Employed full-time (35+ hours per week)	20	18%
	Employed part-time (<35 hours per week)	19	16%
	Unemployed, looking for work	19	16%
	Unemployed, disabled or currently unable to work	34	30%
	Unemployed, volunteer work	3	3%
	Unemployed, retired	10	9%
	Unemployed, not looking for work	8	7%
	Leave of absence from work	1	1%
Ever served in military			
	Yes	4	4%
	No	107	96%

Participants' mental health history information also was collected during the Time 1 interview. As shown in Table 3, nearly all of the evaluation participants (94%) had seen a professional about mental health problem, and 82% had been formally diagnosed with a mental illness. Most participants (47%) had a primary diagnosis of depression; 25% had a diagnosis of bipolar disorder; and 15% had a diagnosis of anxiety disorder. On average, participants had been coping with their mental health symptoms for 24 years. Slightly more than half (53%) had been hospitalized for a mental health problem. A third (30%) reported co-occurring physical problems. Nearly 20% had been treated for a drug or alcohol problem at some point in their lives.

Table 3: Participant Mental Health Characteristics (N=114) Participant Characteristics	N	%
Ever see professional about a mental health issue		
Yes	107	94%
No	7	6%
Age, in years, of first encounter with mental health services (range, mean)	7-61	26
Ever diagnosed with a mental illness		
Yes	93	82%
No	21	18%
Most recent primary diagnosis		
Schizophrenia	2	2%
Schizoaffective disorder	4	4%
Bipolar disorder/manic depression	23	25%
Depression	43	47%
Anxiety disorder	14	15%
Obsessive-compulsive disorder	4	4%
PTSD	1	1%
Other	2	2%
Number of years ill, in years (range, mean)	<1-49	24
Ever hospitalized		
Yes	59	53%
No	53	47%
Number of hospitalizations over lifetime (range, mean)	1-20	4
Age, in years, of first hospitalization (range, mean)	9-62	31
Physical health problem		
Yes	34	30%
No	80	70%
Ever treated for a drug/alcohol problem		
Yes	21	19%
No	91	81%
Number of times treated for drug/alcohol problem (range, mean)	1-20	4
Currently being treated for a drug/alcohol problem		
Yes	4	4%
No	110	96%
Has attended Alcoholics Anonymous or Narcotics Anonymous		
Yes	39	35%
No	73	65%

To summarize: The majority of our evaluation participants are Caucasian women in their 50s who suffer from depression, and have been coping with their symptoms for over two decades. Most of our participants are poor, earning $20,000 or less per year, and are unemployed. Many are unmarried, and, we suspect, living alone. Having few financial and/or social support resources, many participants may have been drawn to the inexpensive, community-based mental health help and support that RI provides.

RI Participation

During each interview, we asked participants about their participation in RI. We asked them whether they were currently attending RI groups; about the support they received from their RI groups; and what they liked and disliked about RI. If participants reported that they no longer attended RI groups, we asked them to tell us why they had decided to stop going to their RI groups. We also assessed their knowledge of RI tools, and their ability to give a 4-Part Example. In this Executive Summary, we report evaluation findings related to RI attendance, satisfaction and knowledge.

RI Attendance

Reasons for attending RI. At baseline—the first interview—we asked participants to tell us how they first heard about RI, and why they decided to go to an RI meeting. The most common referral source was a family member or friend (40%), followed by a mental health professional (34%). Other referral sources included another RI group member (18%); the RI website (17%); and another advocacy organization's website, support group or newsletter (12%). In regard to their reasons for attending RI, 68% of participants told us that they first went to an RI meeting for help with a specific problem. Of this group, 25% reported that they first attended RI for help with depression; 21% went for help with anxiety; and 11% went for help with both anxiety and depression. A full list of the problems that first brought participants to RI will be included in the final report.

Current RI attendance. We measured RI attendance in several ways. First, during each interview, we asked participants if they were currently going to an RI group. At Time 1, 109 (96%) of the 114 participants who completed a baseline interview reported that they were currently attending an RI group. At Time 2, 70 (74%) of the 95 participants who completed the three month follow-up interview were attending RI meetings. At Time 3, 47 (57%) of the 83 participants who completed the 6 month follow-up interview were attending RI meetings. Finally, at Time 4, 42 (53%) of the 79 participants who completed the 12 month follow-up interview told us that they were still attending RI groups. At each interview, on average, participants who were attending RI meetings went to groups once a week.

Any RI attendance since the last interview. If participants told us that they had stopped going to RI, we asked them if they had gone to any meetings at all since their last interview. We asked this question since we knew it was very possible that someone might tell us during their Time 3 interview that they were no longer going to RI meetings, but had perhaps gone to a few meetings in the 3 month interval between their Time 2 and Time 3 meeting. And, our results show that this indeed did happen. At Time 2, 80 (84%) of the 95 participants who completed the 3 month follow-up interview had gone to at least one RI meeting in between their Time 1 and Time 2 interview. At Time 3, 61 (74%) of the 83 participants who did a 6 month follow-up interview had attended at least one RI meeting in between their Time 2 and Time 3 interview. At Time 4, 50 (63%) of

the 79 participants who did a 12 month follow-up interview had attended at least one RI meeting in between their Time 3 and Time 4 interview.

No longer attending RI meetings. We looked at the number of participants who stopped attending RI meetings at a particular time point. These are the individuals who told us during an interview that they were no longer going to RI meetings, and had not attended any RI meetings since their last interview. At Time 1, 5 (4%) of the 114 participants who completed the baseline interview stopped going to RI meetings. At Time 2, 19 (20%) of the 95 participants who completed 3 month follow-up interviews had stopped attending RI. At Time 3, 16 (19%) of the 83 participants who completed 6 month follow-up interviews were no longer attending RI meetings. Finally, at Time 4, 11 (14%) of the 79 participants who completed 12 month follow-up interviews were no longer attending RI.

Reasons why participants stopped attending RI meetings. We asked all evaluation participants who reported that they no longer went to RI groups to tell us why they decided to stop attending meetings. The full list of the reasons why participants stopped attending RI meetings, and the number of individuals who listed each reason, will be included in the final report. The "top 5" reasons for quitting RI most frequently reported by participants are: schedule conflicts (45%); recurrence of mental health symptoms or problems (37%); disliked RI meeting format (20%); felt that RI meeting were too boring (20%); and felt that RI meetings were too long (18%) (Note: Participants were asked to list all of the reasons why they stopped attending RI meetings; therefore percentages exceed 100%). As will be better illustrated in the full final report, overall, reasons for no longer attending RI are nearly evenly split between personal factors—schedule conflicts, mental health problems—and RI factors—not liking the RI meeting format, feeling that meetings are too long, etc.

Summary of RI attendance data. Taken together, these RI attendance data suggest the following. First, over the course of a year, it appears that close to half of newcomers stop going to RI meetings. Second, most of the newcomers who stop attending meetings do so within the first six months of initial RI participation. Third, reasons for quitting RI are varied, but nearly evenly split between personal factors—things in the participant's personal life that cannot be easily controlled, such as schedule conflicts or illness—and factors related to RI meeting structure and materials.

RI Satisfaction

We assessed participants' satisfaction with RI in two key ways. First, we used the Client Satisfaction Questionnaire (CSQ), a satisfaction assessment that is used in nearly all evaluations of mental health programs, to measure general elements of RI satisfaction. The CSQ asks participants whether they feel that RI is helpful and met their needs. Second, we asked them to rate their RI group leader's skills. Third, we asked participants to tell us, in their own words, what they liked and disliked about the RI program. We asked participants who were attending RI, as well as those who were no longer attending RI, these satisfaction questions. For this Executive Summary, we

report satisfaction data reported by all participants. In the final report, we will compare satisfaction results between those who attended RI across all four interview time points, and those who stopped attending RI at some point in the study.

CSQ and instructor satisfaction. CSQ results show that, at each interview time point, on average, participants express moderately high levels of satisfaction with RI meetings. They felt that the meetings were helpful, met their needs, and that they would recommend RI to a friend who was experiencing similar problems. Evaluation participants also reported at each interview that their group leader was very good, and did a good job leading the group.

Evaluation participants were asked during their interviews to list three things that they liked most about RI; three things they disliked about RI; how RI was helpful to them; and how RI was unhelpful to them. For this Executive Summary, we report results from the Time 1 interviews for all participants. The final report will present results for all interview time points, and will compare responses made by those who attended RI throughout the study, and those who did not.

RI likes. At Time 1, evaluation participants gave a total of 323 responses for the question, “What three things do you like most about RI group meetings?” Responses were coded by evaluation staff into 12 categories. The three most frequently reported “likes” were: (1) RI structure and methodology (97 responses); (2) The RI group itself (49 responses); and (3) peer support provided by RI. These results suggest that evaluation participants strongly value RI’s format, the tools, and 4-Part Example. Many participants reported enjoying RI groups because of the people involved, and the open, friendly and structured atmosphere of RI. Finally, participants listed peer support as one of the things they liked most about RI. They specifically appreciated that the RI group leaders are peers, and valued being in a group with individuals who are facing similar challenges.

RI dislikes. Evaluation participants gave a total of 195 responses at Time 1 for the question, “What three things do you like the least about RI group meetings?” Responses were coded into 9 categories. The three most frequently reported “dislikes” were: (1) RI format and structure (46 responses); (2) RI materials (33 responses); and (3) other group members (33 responses). Participants told us that they did not like specific aspects of RI group meeting format, including its length and the lack of opportunities to speak in the group. In regard to materials, participants reported that the language in Dr. Low’s books is outdated, and difficult to understand. Finally, participants mentioned problems with other group member as something they did not like about RI. This included poor attendance by other group members (i.e., few people attending a meeting), difficulties getting along with other group members, and not feeling welcome at a group.

Helpfulness of RI group meetings. Participants gave a total of 249 responses at Time 1 to the question, “How are Recovery group meetings helpful to you?” Responses were coded into 10 categories. The three most common responses

included: (1) RI materials and curriculum (86 responses); (2) RI helps me feel better (47 responses; and (3) peer support (35 responses). Participants told us that RI tools, Dr. Low's books, the 4-Part Example, and RI's positive message were program elements that they found to be most helpful to them. They told us that RI helps them feel better: they have fewer mental health symptoms and feel less angry, anxious and depressed. Peer support also is stressed in participants' responses to this question. Participants reported that they valued hearing others group members' stories, and receiving members' feedback.

Unhelpfulness of RI group meetings. At Time 1, evaluation participants gave a total of 121 responses to the question, "How are Recovery group meetings not helpful to you?" Responses were coded into 9 categories. The three most common responses included: (1) nothing—RI is helpful to me (66 responses); (2) RI format (16 responses) and (3) other group members (14 responses). It is very important to note that more than half of the participants could not answer this question—i.e., said nothing about RI was unhelpful—because they felt that the group was helpful to them. In regard to what some participants did feel was unhelpful, some participants reported that the format was problematic for them. This included statements about not being able to share as much as they would like, having difficulty remembering and applying RI methods, and feeling that the format was unsympathetic. Other participants described problems with other group members, which included both being bothered by group members who had more severe mental health symptoms and wanting to have closer friendships with other group members.

Summary of satisfaction data. Overall, satisfaction results suggest that evaluation participants were very satisfied with RI group meetings. They felt that the information and tools they received met their needs, and that group leaders are qualified and do a good job facilitating meetings. They felt that RI's structure, tools, and 4-Part Example are helpful, and that RI promotes a positive, open environment. Participants particularly liked that groups are led by peers who face similar challenges. A notable area for improvement, as reflected in the dislikes, is an update of Dr. Low's books. Some participants told us that they felt the books were too hard to understand and that some of the language was sexist and outdated. However, the majority of participants felt that RI is helpful to them, and gave them important skills that help them better manage their daily lives.

RI Knowledge and the 4-Part Example

RI knowledge. We developed a 17-item multiple choice questionnaire that assesses evaluation participants' knowledge of RI methods and tools. We asked all participants these 17 knowledge questions regardless of their RI attendance status. In the final report, we will share results that compare RI knowledge scores of those who attended RI at each interview time point to those who had stopped attending RI. At each interview time point, knowledge scores ranged from 0 correct answers to 17 correct answers. On average, at each interview, participants had a total of 13 correct answers. This indicates very good knowledge of RI methods and tools. These results also

suggest that participants were able to quickly learn this information, and that RI knowledge remained stable over time.

4-Part Example. To examine whether participants learned how to give a 4-Part Example, we asked everyone to give us an Example during their interviews. Participants received one point for each part of the Example they gave correctly. Example scores ranged from 0 (no parts given correctly) to 4 (all parts given correctly). At each interview time point, on average, participants gave 3 of the 4 parts of the Example correctly. The final report will describe in detail which specific elements of the Example were given correctly and incorrectly at each interview time point. Again, similar to knowledge, these results suggest that participants quickly learn how to give an Example, and that their knowledge and ability to give an Example remains stable over time.

RI Participation Benefits

We were interested in learning how RI participation influences changes in several key areas of newcomers' lives, such as their mental health symptoms, feelings of empowerment and hope, self-esteem, and service use. During each interview, we administered questionnaires that assessed these outcomes. We conducted General Linear Model-Analysis of Variance (GLM-ANOVA) tests for each outcome to see if newcomers experienced significant changes in RI participation benefits over time. For this Executive Summary, we report whether any significant changes occurred for all participants. The final report will include analyses that compare participants who attended RI at each time point, and those who did not. It also will describe relationships between attendance, knowledge and participation benefits.

Significant changes in outcomes from the Time 1 to Time 4 interview include:

- Decreased severity of mental health symptoms
- Decreased depressive symptoms
- Decreased anxiety symptoms
- Increased overall mental health recovery
- Improved confidence in one's own ability to achieve mental health recovery
- Increased willingness to ask others for help and support
- Decreased mental health symptom domination (life is not controlled by one's symptoms)
- Increased feelings of hope
- Improved self-esteem
- Increased coping mastery ability
- Increased social connectedness/support
- Increased agreement with public stereotypes of mental illness
- Fewer mental health and social service needs
- Less use of mental health and social services

These results indicate several important benefits of RI participation. First, over time, participants report experiencing fewer, and less severe, mental health symptoms. Most notable, they report experiencing fewer depressive and anxiety symptoms. They

report an increased belief and confidence in mental health recovery, and that their own recovery is possible. Participants report significant decreases in symptom domination: their mental health symptoms do not control their life. Along with this, they report feeling more hopeful over time, have enhanced self-esteem and coping ability, and experience more social support. Finally, participants report that, over time, they need and use fewer mental health and social services.

Preliminary Conclusions

Since analyses are ongoing, we make only preliminary conclusions about evaluation results for the Executive Summary. This is not because results will change; rather, our more extensive analyses will enrich our interpretations. For example, we may find a dosage effect for improved benefits, i.e., that attending a greater number of RI meetings is significantly associated with decreased symptoms.

What do we know at this point? Most newcomers are middle-aged, low-income Caucasian women who seek out RI for help with anxiety and/or depression. It appears that most newcomers decide within the first six months of RI attendance whether they will continue to participate in meetings. Those who chose not to attend primarily drop out of RI due to personal reasons (e.g., schedule conflicts) but several also note meeting factors (e.g., meetings are too long and boring) as reasons for their non-attendance.

Overall, newcomers are very satisfied with RI, and report that the RI Method meets their needs. They like that the tools and the 4-Part Example are strategies they can use deal with problems that happen in their everyday lives. Despite the fact that some participants told us that they felt that the language was outdated or hard to understand, our results related to RI knowledge and the 4-Part Example indicate that newcomers quickly learn RI tools and how to do the Example, and maintain this knowledge over time.

Our results related to RI participation benefits suggest that newcomers don't just learn RI concepts; they quickly learn and apply the Method in their daily lives. Most of our evaluation participants told us that they initially attended RI for help with anxiety and/or depressive symptoms. One year after they went to their first meeting, evaluation participants reported significant decreases in the number and severity of their anxious and depressive symptoms. Additionally, they reported that their mental health symptoms did not dominate or control their lives. And, perhaps most important, participants reported increased confidence in their ability to achieve their own mental health recovery. Taken together, these findings suggest that: (1) participants received help for the problems that first brought them to RI; (2) they learned and applied strategies to help them cope more effectively with their problems; and (3) in so doing, began achieving their mental health recovery.

Increased willingness to ask others for help, improved social connections with others, and increased feelings of hope reflect the peer support inherent in RI. Group

leaders are peers who face similar challenges, and are positive role models of what RI can do. Giving and receiving feedback from peers within group meetings helps decrease participants' feelings of isolation and loneliness, and helps build social support. This peer support and connections with others are vital to people struggling with mental health problems, particularly those whom, like our newcomers, may have few people to turn to for help.

Since we did not conduct a randomized clinical trial—a very large study where we would have randomly assigned people to go to RI meetings or to another group, and then compare the two groups on these participation benefits—we cannot conclude that RI participation *alone* is the reason for these improved outcomes. What we can say is that these benefits occurred for people a year after they first started going to RI meetings. In the final report, we will explore the factors that may help explain these participation benefits. For example, we are currently conducting analyses that look at the role of RI attendance on these outcomes to find out if there is a dosage effect (i.e., do participants who attended many RI meetings have greater decreases in mental health symptoms than participants who only went to a few meetings?) as well as differences between participants who went to meetings throughout the year and those who stopped going to RI meetings. We also will examine whether participants' demographic and illness characteristics are related to RI attendance and satisfaction, and participation benefits; and how RI knowledge and ability to do the 4-Part Example are associated with changes in outcomes.

In sum: RI is an important resource for individuals who have been struggling for many years with depression, anxiety and other mental health problems. It provides the skills and support participants need to better manage their symptoms and not allow their illness to control their lives. To paraphrase many of our participants' comments about RI: This peer-led, community-based program is a lifesaver.