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Study Title:
Testing the Effectiveness of a Brief, Peer Support Intervention to Facilitate Transition from Psychiatric Hospitalization

Principal Investigator:
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STUDY PROTOCOL
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Introduction

Goal:

The goal of this study is **to generate an effective, readily implemented intervention to support individuals with schizophrenia in transition to communities after lengthy hospital stays**. This is a topic of importance given that, in Canada, approximately 75% of people with schizophrenia have been hospitalized, 38% are readmitted within 1 year, and the average length of stay is 27 days[1,2]. This rate of readmission is considerably higher than other mental illnesses, with the first month post-discharge highlighted as the period of greatest risk for poor outcomes such as suicide, disengagement from care, and readmission[1,3,4]. Such outcomes reflect poorly aligned inpatient and outpatient sectors[5], with few interventions articulated in the small and variable literature in this area[6].

Objective and outputs:

Building upon evidence of the benefits of peer support in the transitional period[7,8] and our previous success with developing and proving the feasibility of a brief peer transitional intervention[9], **the objective of the proposed study is to test the hypothesis that this intervention will improve the discharge-related outcomes of individuals with schizophrenia. The proposed approach is unique** in its brief, critical time orientation, its provision of basic living supplies, its community engagement emphasis, and the application of evidence-based compensatory cognitive strategies. Effectively disseminated, the **outputs would align with system priorities**: the need to reduce rehospitalization rates, the need for resource-lean approaches, and the need to generate evidence for peer support. Peer supports are increasingly emphasized as an important resource in mental health care[10] and this intervention plays well to the skill sets of peers.

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Context and need:

Of the major mental illnesses, which are responsible for 3.8% of hospital admissions in Canada[2], schizophrenia is the most costly[11]. Generating effective services for this condition has been a persistent challenge hampered by its complexity – requiring, for most, combinations of psychosocial and pharmacological interventions that are difficult to access and have modest effectiveness[12]. In considering complex needs in resource challenged systems, leverage is important. Discharge from hospital is a point of systemic leverage, and the authors of the proposed study having designed a brief intervention for this period tailored to the unique needs of individuals with schizophrenia. This work is timely not only in that it addresses a clear gap in the practice literature, but also in its addressing priorities of the Mental Health Strategy for Canada[10], including the need to create better means of bridging care from hospital to community and the use of peer supports. Peer support involves individuals with lived experience of mental illness engaging clients in relationships and activities to support recovery that are grounded in empathy and shared experience.

Background:

In a recent systematic review, Vigod and colleagues[6] identified 15 studies in this area. Interventions varied markedly, with components including pre-discharge activities (e.g., psychoeducation), post-discharge activities (e.g., phone follow-up), and bridging activities (e.g., transition manager meets outpatient clinician). The authors concluded that these interventions, regardless of type, were associated with service process and outcome improvements, with 7 studies demonstrating a positive effect on re-admission rates (13.6-37.0% reduction). **Peer support is a promising approach in this area**. Peers, to a greater extent than professionals, focus upon what clients perceive as the main challenges (marginalization, poverty, stigma) that attend discharge[13]. Integrating peer supports into the discharge process with up to a year of follow up has been associated with improvements in social aspects of quality of life and lower emergency service use[7] and up to 3 months of a peer-facilitated group follow-up has been associated with a 50% reduction in readmission rates[8].

Preliminary work:

This proposal builds upon the emerging evidence in this area. The authors have already demonstrated the **feasibility of a brief peer-facilitated transitional intervention that uniquely targets the most critical period post-discharge**. Initial study of the intervention demonstrated its ready uptake in clinical service, associations with improved community functioning, engagement, and quality of life, and a trend towards lower readmission at 6 months post-discharge[9]. The authors have also developed a training model for building capacity in the use of this approach.

Anticipated contributions:

A critical next step in this line of investigation is to prove effectiveness and optimize efficiency. The proposed research would accomplish this objective and, if successful, make a compelling case for services to adopt this approach. **The deliverable would be a manualized, clearly articulated peer intervention and clear guidance for implementation**. It would be disseminated internationally through the established networks of the investigators and help address the critical, systemic disruption of service that attends discharge from hospital and its

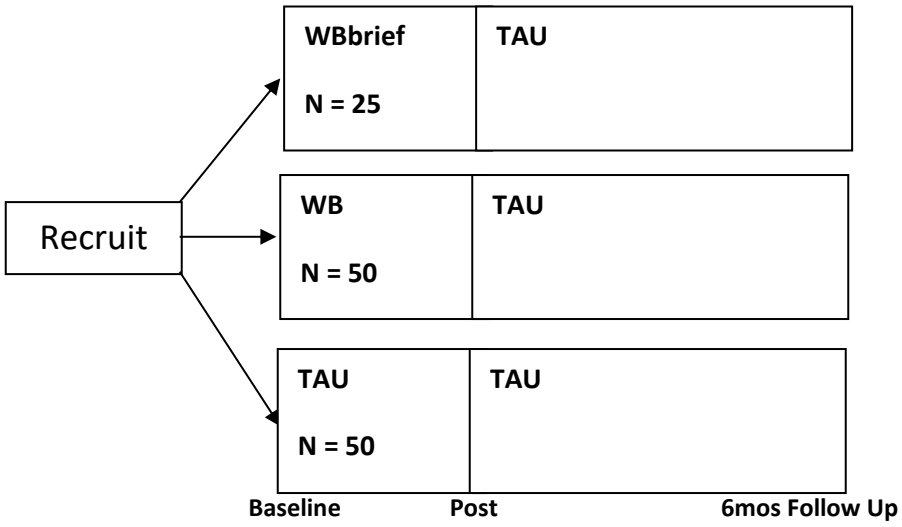
substantial impacts from individual to economic levels.

Methods

1. What is the proposed trial design?

This study will focus on two objectives. First, it will provide data about the effectiveness of the Welcome Basket (WB) intervention, which has demonstrated feasibility and is associated with positive outcomes[9]. In the proposed trial, we hypothesize that the WB will be proven effective as compared with treatment as usual (TAU) in service use and clinical domains. Baseline measures will be completed in the week prior to discharge, at 4 weeks post discharge to assess short-term impact, and at 6 months post-discharge to assess sustainment of gains. Assignment for this single blind trial will be random.

Figure 1 – Trial Diagram, Measure Summary, Study Timeframe



Measures:
Community Functioning **(primary)**
Hospitalization
Quality of Life
Community Involvement
Symptomatology
Recovery Process Engagement

Along with the intended outputs of the Welcome Basket (WB) Trial were a clinical outcome paper and a process paper on WB implementation. During initial meetings for the process paper, we have discussed that it is necessary to interview the peer support workers on the trial in order to get an in depth understanding of how peer support is implemented. The process paper will illustrate how peer support workers implement peer support at an individual level as well as the successes and barriers that occur for peer workers at both the individual and system levels. This understanding will allow for recommendations to be made as to how peer support work can be done successfully and how to best troubleshoot challenges that may arise during

implementation.

Study Timeframe

Activity	Months:	0	6	12	18	24	30	36
Staffing/Setup		>>						
Recruitment (6/month)		>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>						
Intervention								
		>>						
>>								
Measures		>>						
Data Analysis					>>>>			>>>>
Knowledge Exchange								>>>>>>>>>

2. What are the planned trial interventions

Experimental Interventions

1. Welcome Basket Intervention: The Welcome Basket (WB) intervention is based in part upon the original model established in New Haven, Connecticut in 1996[8]. However, this version of the WB differs from the original in its brevity (original involved several months of follow up), use of 1-1 outreach (as opposed to group meetings), and employment of compensatory interventions. In the proposed study, Peer Support Workers (PSWs) hold 1-2 initial meetings with clients (typically 30-60 minutes) in the 2-week period before they are discharged from hospital. In these meetings they will describe the program and undertake an assessment of the individual's needs and interests as they pertain to their transition to the community. From this assessment the two core components of the intervention are initiated. First, a "welcome basket" is created based upon the assessment, containing staple supplies, plants, coupons for stores nearby the client's residence, and comfort items within a modest budget (for the purposes of this study the budget will be up to $40/basket). The PSW also forms a plan with the client about tours of their neighbourhood to familiarize them with the local resources (e.g., low cost entertainment venues; libraries; parks; inclusive spaces) and support them as needed in building confidence in accessing their local communities. These activities will take place through weekly visits (typically 2 hours/visit) in the 4 weeks immediately following discharge. WB will be provided in combination with core Cognitive Adaptation Training (CAT) compensatory interventions[14]. These include the setting up and placement of a calendar, lists of daily activities, signs that prompt recall of tasks, basic organization of living space, and the use of alarms and reminders (CAT supply budget of $25). These supports are important (and often overlooked) in many clients' efforts to establish self-sufficiency after many weeks and months in hospital where staff typically initiate and structure the majority of activities.

In our recently completed mixed methods study of process and outcome indicators for 23

participants who received the WB, we observed staff and client qualitative reports of successful implementation and outcome. We also observed significant quantitative changes in community functioning (ES = 0.64), domains of quality of life (ES = .38 – 1.28), psychological community integration (ES = .51) and a trend of lower rehospitalization at 6 months post-discharge as compared with average readmission rates on referring units.

2. Welcome Basket (Brief) Intervention: The brief version of the Welcome Basket (WBbr) was developed based upon the observation in feasibility testing that for some participants much of the benefit of this approach appeared to be centred upon the visits immediately prior and subsequent to discharge. In the WBbr the same core components will be present, albeit in an abbreviated form with one 30-60 minute visit in the week prior to discharge and a single, 3-hour visit in the week subsequent to discharge in which the welcome basket would be delivered, core CAT strategies discussed and implemented, and some basic orientation to community resources undertaken. This brief version of the intervention has not to date been studied.

Treatment As Usual

Treatment as usual (TAU) involves the typical discharge procedures for clients from Unit 2, Forensic and EPU wards at CAMH. It includes referral to outpatient psychiatric services and relevant community supports with the transition facilitated by inpatient social work staff.

Controlling for Case Management

It will be a requirement that all clients enrolled in the study are engaged in some form of community-based case management along with medical follow-up. This strategy will assist in controlling for outcome variance impacted by conditions other than the intervention being studied.

Peer Support Worker Training and Clinical Context

Inpatient and outpatient clinicians and administrators are familiar with the intervention and regarded it positively from feasibility testing through to its current, ongoing delivery. There are currently 5 Peer Support Workers on staff who are extensively trained in the WB intervention. They were initially trained by Mr. Richard Weingarten who developed the original WB intervention in New Haven and were trained in compensatory intervention by CAT specialists in collaboration with Drs. Velligan and Maples.

Participant Allocation and Blinding

For the trial, blocked randomization at a 2:2:1 ratio (TAU:WB:WBbr) will be employed to ensure balance in sample size between treatment and control groups. Stratification will not be employed as feasibility study findings did not suggest significant variance attributable to demographic or treatment history factors. Study measures will be collected by research assistants blinded to the treatment condition.

3. What are the planned inclusion/exclusion criteria?

1. Participants will be adults, 18 years of age or older, with a chart diagnosis of a schizophrenia spectrum mental illness or bipolar disorder with psychotic features confirmed by Module B (psychotic symptoms) of the Structured Clinical Interview for DSM-5 (SCID-

5)[15]. All participants will be on CAMH inpatient units at the time of recruitment and will have been in inpatient care for close to or more than 2 weeks. This timeframe is guided by the rationale and experience indicating that an overly brief period of hospitalization circumscribes the relevance of the intervention.
2. Participants will be returning to places of residence in the Greater Toronto Area (catchment of CAMH).
3. Participants must have been referred to outpatient case management.
4. Proposed housing arrangements must be stable and conducive to the intervention. If homelessness or emergency shelter residence appears likely, or boarding home policy precludes any external staff from entering the premises, such individuals will be excluded.
5. Proficiency in English.

4. What are the proposed primary and secondary outcome measures and qualitative feedback?

Primary Measure: Community Functioning will be assessed with the Multnomah Community Ability Scale (MCAS)[16], a 17-item scale assessing domains of functionality including health, adjustment to living, social competence, and behavioral problems (completed at all time points). This measure best reflects the primary aim of this intervention: to support a greater degree of illness self-management, independence, and level of community activity. The MCAS will be scored based upon interviews with participants primary clinician (inpatient for baseline and case managers for post and follow up measures).

Secondary Measures (All inventories have established psychometrics with this population.)

1. Hospitalization as assessed at 4 weeks and 6 months post-discharge (number of rehospitalizations and lengths of stay captured through case manager report and verified through hospital electronic database if a CAMH hospitalization).
2. Quality of Life (QoL) will be assessed with the Satisfaction With Life scale (SWLS)[17], an 18- item scale that has subscales assessing living situation, social relationships, work, self and present life. SWLS will be assessed post intervention and at follow up (would not be valid during inpatient stay due to contextual confounds with items). QoL will also be assessed using the Social Support Survey[18], a 19 item scale that measures emotional/information support, tangible support, affectionate support and positive social interaction (all time points)
3. Symptomatology will be measured using the 53 item Brief Symptom Inventory[19] (all time points) and the 23 item GAIN Short Screener (GAIN-SS)[20] (all time points).
4. Recovery Process Engagement will be measured with the brief, 10-item version of the Personal Recovery Outcome Measure[21] (all time points).
5. Community Involvement will be assessed with the 11 item Community Integration Scale which was developed for the At Home study with a comparable population to assesses psychological and behavioural community engagement[22]. Community Involvement will also be assessed with the Social Functioning Scale[23]. Community Involvement will be assessed post intervention and at follow up (would not be valid

during inpatient stay due to contextual confounds with items).

6. Descriptive Measures include core demographics (gender, ethnicity, sexual orientation, age, education, etc.; assessed at time 1) and service use history (history of hospitalization, physical and mental health service use, community services; assessed at baseline and updated at each contact). Amount of contact in hours/month with a person or persons (other than providers; e.g., family) regarded as an important supports by participants will be captured. This will help in determining if non-service supports are a relevant covariate in considering outcomes.

Qualitative interviews: The current peer support workers involved with the Welcome Basket study will be asked to participate in an open-ended interview that will ask how they engage in peer support work with clients as well as successes and challenges that occur at both the individual and system level. After obtaining consent, the graduate research assistant will conduct a 1-hour interview with the peer worker (see Appendix 2).

5. What is the proposed sample size and analysis strategy?

The primary objective of this trial is to test a difference between the full WB intervention and the control condition with an alpha level of 0.05 and a power of 80%. An additional pilot study of the WB brief intervention is proposed with an approximate 0.05 alpha level, at 50% power. While multiple testing has not been corrected for, the intention is not to power this trial to detect these differences but rather to gather the necessary preliminary data on the average effect and variance of response in the brief intervention group to determine whether further testing is indicated and sufficient data to allow for power calculations for a follow-up trial. The target sample is thus 125 participants with a 2:2:1 randomization ratio of TAU to full WB to WB brief. Accounting for an estimated 13% attrition rate (observed in the feasibility study) this sample size would result in 44 completers/group for the main intervention and control groups and 22 completers in the brief intervention group. Based on MCAS means and the pooled standard deviation observed in the feasibility study (assuming no beneficial change in MCAS in the control group), and using a superiority trial power calculation[24], this sample size will allow for the detection of medium effect sizes at 80% power.

The data analysis strategy is as follows: (1) We will examine treatment and control groups at baseline on demographic variables and flag any clinically significant differences that might confound outcomes. (2) We will develop a descriptive profile of session attendance. We will consider the participant as having been exposed to the intervention if they have attended at least 50% of sessions. (3) We will compare the full WB intervention group and the control group on changes in hospitalization, community involvement, community functioning, quality of life, and symptomatology from baseline to week 4 post discharge. Analysis of variance (ANCOVA) will be used for this comparison with the above variables being the dependent measures and treatment group being the independent variable controlling for MCAS scores at baseline. (4) Differences over time in these variables from baseline, to 4 week and 6 month follow up measures will be

analyzed using mixed-effects linear modeling. For these analyses, a time effect will reflect changes across groups over time, and the group-by-time interaction will reflect changes over time between the groups. For all analyses $p < .05$ will be used as the level of significance with Cohen's *d* effect sizes reported. A blinded interim analysis will be conducted to determine if the sampling estimation needs to be revised. Plotting, mean and variance estimates will be calculated using the data from the WB brief treatment arm and compared with the control and full treatment.

All interviews will be recorded and transcribed by the graduate research assistant and undergraduate volunteers. Two independent researchers will code the transcripts using thematic content analysis[25], in order to analyze common themes that occur within the data. The PI will resolve any discrepancies that occur within the qualitative analysis. The themes will be brought back and discussed with the peer workers and WB team. Any other comments or themes that arise from this discussion will be documented using field notes[26].

6. Data Management and Integrity

The basic protection against risk in this study will be provided by Dr. Sean Kidd (study PI). The PI will have primary responsibility for monitoring of participants during the entire time they participate in the study. The PI will meet regularly with study personnel to review accrued data, data confidentiality, and adherence to protocol design, recruitment, and participant complaints. During meetings the Study PI will also review the enrollment data, the accrual and integrity of clinical data, and any adverse event associated with the various components of the study. If a serious adverse event occurs during the study, it will be reported to REB.

All data pertaining to a participant's involvement in this study will be coded and stored in locked offices. This information will only be accessible to the research team. In unusual cases, a participant's research records may be released in response to a court order. If the research team learns that a participant or someone with whom the participant is involved with is in serious danger or harm, an investigator will inform the appropriate agencies as per legal or regulatory requirements.

The hard data are stored in a locked filing cabinet stored in a locked office to further protect participant anonymity. Data auditing, entry and quality control will be carried out at regularly. Regularly scheduled, and as needed, communications between the study team and the Study PI will clarify any inconsistencies and ambiguities in the data.

Study data will be entered in a secure database (REDCap). At point-of-entry, data values will undergo consistency edits (e.g., ID validation, range verification, duplicate detection) and personnel will be required to correct errors. Data management staff will run logic error programs to check for accuracy and irregularities within and across data structures and within and across sites. Quality assurance checks will be conducted daily and weekly by site personnel, as well as

by data management staff.

7. Recruitment, Consent, Risk and Risk Mitigation

The estimated rate of 5-6 individuals screened into the study per month is feasible based upon the previous study and is readily accommodated in a large service of over 150 beds relevant to study recruitment. Participants would be referred to the study by inpatient unit staff – primarily Social Workers engaged in discharge planning who will be oriented to the study. Specifically, inpatient clients meeting eligibility criteria who are expected to be discharged in 1-2 weeks and deemed capable of providing consent or have a substitute decision maker (SDM)who can provide consent to participate in the study will be approached by inpatient staff, the project briefly described to them, and their permission sought to be approached by research staff (see script). The treating physician/clinical care team will not obtain consent.

A physician investigator or trained research personnel will obtain informed consent from the participant or SDM. Participants and SDMs will be provided with a clear explanation of the objectives, procedures, risks and benefits of the study and all questions will be answered. Questions will be asked of subjects to ensure that they understand the nature of the research, the risks and potential benefits of study participation, and their rights as research subjects prior to obtaining their signature on the informed consent document. Because we believe that consent is an ongoing process in any study, we will continue to educate subjects about the nature of the research and address any questions that may arise throughout the course of the study. In cases where SDM consent is required, as a first step the principal investigator will liaise with the Medically Responsible Person (MRP) and Case Manager (CM) to assess mental status and benefit of participation.

Three conditions will be necessary for enrollment:

1. At least one clinician (MRP and/or CM) provide documented agreement regarding the appropriateness of involvement in this study
2. Documented participant assent
3. Documented SDM consent

If a participant does not assent and the substitute decision maker consents the participant will not be enrolled.

Participants who are referred from the inpatient units to the Slaight Centre for Youth in Transition (SCFYT), will be recruited and pre-screened with the REB approved “pre-screen form” that is implemented across all Slaight studies. At SFCYT, case review meetings are conducted twice a week to review recruitment and to identify new patients who may be eligible for research studies. With their assent, research staff will then meet with potential participants, describe the study in detail, and obtain consent. With 60-70 discharges taking place across relevant wards every month,

we have a large pool of potential participants from whom to draw.

Following provision of written informed consent, all participants will be assessed for suitability for inclusion in the study based on the inclusion and exclusion criteria. If it is deemed necessary, research staff may review participants' CAMH medical charts to obtain additional information to confirm their eligibility or to obtain clinically relevant information for research purposes and the contact information of their case manager. The study team will also have access to the participant's health records in order to document their participation in this study into their CAMH health record. The investigator or research staff may also request information from the participant's physician and/or a member of their case management team after obtaining consent for release of personal health information to determine eligibility.

Ongoing experience with the delivery of this intervention over the past 3 years has resulted in both confidence that this study will not run into substantive challenges as well as knowledge of an array of problem mitigating strategies. Recruitment has at times slowed, though this has historically been addressed readily through meeting with managers who in turn encourage teams, engagement of the Social Work practice group, and presenting at team meetings. In this period there have been no adverse events in the delivery of this intervention, it has proven feasible, and outcomes associated with its delivery have been positive.

Additionally, as part of the CLEARR (Clinical Engagement and Research Recruitment) initiative, a delegated Research Coordinator under the supervision of a CLEARR team recruiting clinician and accountable to the Research Manager will identify potential participants and notify the research team and the participant's clinician about their eligibility to participate in the study. The clinician will then ask their client if they would be willing to meet with a study team member about participating. Only with clients' agreement will they be approached.

The delegated Research Coordinator will access personal health information (PHI) in I-CARE in order to determine eligibility of CAMH clients to participate in the research study. No PHI except MRN will be collected for this purpose and this information will be kept in a secure locked location per Research Standard Operating Procedures SOP# CR501.

All clients will be given the option to participate. Participation in the study is voluntary. The decision to participate will not affect patients' receipt of treatment or clinical services. Participants will be informed that they have the option of terminating their participation at any time, without consequence and that no new data will be collected on them. Any existing data will be anonymized.

Recruitment of Peer Support Workers

There are currently three peer support workers involved with the Welcome Basket study. All three workers will be asked to participate in the interview in order to best understand how peer support is employed within the WB study. Each peer support worker will need to provide fully informed consent.

Termination of Study:

Reasons for withdrawing individual participants from the study may include one or more of the following:

a) Major protocol violation

b) Participant lost to follow-up c) Withdrawal of consent

Any participant may be discontinued from the study at the discretion of the investigators if this is

deemed to be in the best interest of the participant. The decision may be made either to protect the participant's health and safety, or because it is part of the research plan that people who develop certain conditions may not continue to participate.

Confidentiality

There is a potential risk of breach of confidentiality that is inherent in all research protocols. Breach of confidentiality will be minimized by the staff who will maintain research data (identified only by participant code number not related to name, or date of birth) in separate charts and a dedicated password protected electronic database. A list of participant names, their ID numbers, and information about how they can be reached will be kept in a separate locked cabinet with access only to study personnel authorized by the PI. Procedures have been established, and will be followed, to minimize the risk of breach of confidentiality. Procedures to maintain confidentially include: (1) formal training sessions for all research staff emphasizing the importance of confidentiality; (2) specific procedures developed to protect participants' confidentiality, and (3) formal mechanisms limiting access to information that can link data to individual participants. All information obtained from participants will be kept as confidential as possible. Computer based files/data will be entered into password-secured databases and paper-based files will be stored in a secure location. These data will only be accessible to personnel involved in the study and they will abide by confidentiality regulations of the REB. The ethics committee will be granted direct access to the study participants' original medical records for verification of clinical trial procedures and/or data, without violating the confidentiality of the participants, to the extent permitted by the law and regulations.

Research data gathered as part of this study may be shared and provided to other investigators affiliated with the Slaight Family Centre for Youth in Transition (SFCYT) at CAMH for the purpose of data sharing. If participants are enrolled in multiple studies, their research data will be shared across studies to reduce participant burden and avoid duplication of procedures. Only investigators/research team affiliated with SFCYT Centre will have access to secured files and/or research data and will be well-informed regarding the protection of participants' rights to confidentiality.

Furthermore, investigators collaborating with SFCYT Centre (or other secondary investigators) will have access to the research data collected during the study for the purposes conducting secondary analyses about mental illnesses, such as autism spectrum disorder, depressive disorders, psychotic disorders, bipolar disorders, anxiety disorders, sleep disorders, substance use disorders or dementia (e.g. Alzheimer's disease). This data will be anonymized and not contain any PHI.

Participants will not be identified by name in any publication of research results. Results will be

published as group data without the use of characteristics that would identify individual participants.

8. Knowledge Translation: An array of knowledge exchange activities will occur following the successful completion of this trial. They will include: (i) publication in a relevant academic journal of good impact, (ii) presentation in at least one national or international conference with a focus upon practitioner and administrator audiences, (iii) a webinar advertised internationally through research, practice and administration networks, (iv) over the course of the study delivering 1-2 full day trainings in the intervention for peers and administrators which itself will be evaluated and enhanced, becoming a core CAMH training offered in the future, (v) manualizing the intervention and making it freely available on a website dedicated to the intervention on the CAMH Portico site, and (vi) cultivating an online community of practice on the website.

Data generated from qualitative interviews will be used to create a case study of the WB intervention that will address how peer support is implemented within a hospital setting, from the perspective of the key stakeholders. The information will highlight the successes and challenges that occur for peers as they engage in peer support work, addressing a substantial gap in the present literature. This case study will be submitted to an academic conference for a poster session as well as a manuscript for publication.

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Appendix 1 – Clinician Script

I would like to tell you about a project that his happening called the welcome basket. Some researchers at CAMH are trying to figure out ways that people could transition or move from hospital to their home in the community with more success – in other words, trying to make it a smoother process and provide some resources. Getting involved would mean that you'd randomly receive one of three things – like in a coin toss. You would either receive:

-A service led by a Peer Support Worker. A Peer Support Worker is a CAMH staff member who has experienced mental illness and works to support CAMH clients. They would provide you with basic supplies you might need when you get home in a "welcome basket", and they would then meet with you once before you leave hospital and once week for a month after you leave. In that time they would get you supplies that you might need to help keep your home organized and help with things like calendars and reminders that could help you with getting started with your goals. They would also, if you were interested, take you out to places in your community such as events, coffee shops, and restaurants to help you connect or reconnect with your neighborhood.

-A service that would be the same as the one that I just described, except it would involve just two visits – once before you leave hospital and once shortly after you are discharged from hospital.

-Or, you'd leave hospital as you normally would without these supports – the same as originally planned.

The overall point of the project is to see if we can help people transition to the community more smoothly – becoming connected with community, making sure they have some basic necessities for the move, and being given tools to help address the impacts that psychosis can have in areas such as attention and memory.

This is being researched. That would mean before it started and at the end you would complete some surveys about how you are doing. You'd get paid for those meetings.

You don't need to take part in this. Saying 'no' is fine – it won't affect any of the services you get here. If you are interested, though, I would put you in touch with a project coordinator who would tell you more about it. What do you think?

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Appendix 2

Welcome Basket Peer Support

1. During your first meetings with a WB client, what do you typically focus on?
2. What is the usual progression of the content throughout the WB intervention? (i.e., from session 1-4)
3. What do you perceive is your role in the intervention?
4. What do you perceive is the client's role in the intervention?
5. What do you hope to achieve when you are working with WB clients?
6. How does the WB intervention create or sustain changes in clients? Probe: challenges, barriers.
7. What is the role of the person's context in the intervention and how does that affect the effectiveness of the intervention? (e.g., gender, ethnicity, housing, etc.)
8. What are some challenges that occur when you are working with WB clients?
9. How have you resolved these challenges?

Role as a Peer Support Worker in WB

10. How has being in the WB program affected your position as a peer support worker?
11. What are the strengths/challenges of working within a research and RCT format?
12. How is the WB different from other peer support interventions you have been involved with?
13. What are the strengths/ weaknesses of the WB?
14. What system level barriers have you run into as a peer worker while working on the WB project?
15. How have you resolved these challenges?

Implementation of WB

16. How do you carry out the logistics of the WB (e.g., money, travel, etc.)
17. How do you create connections with inpatient/outpatient teams in order to carry out the intervention successfully?
18. How have issues with power within the team/hospital been handled?
19. How is peer support within the hospital context different than community?
20. What implementation barriers have you run into while working on the WB project?
21. How have you resolved these challenges?
22. Where do you think peer support is going?
23. Are there any other considerations that need to happen? How would you do this differently?

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Budget

Budget Justification (Total $259,598 – 3 years)

Personnel (Subtotal: 226,229)
Staff will include (i) one 1.0 FTE research assistant who will manage data, communications, and collect data (135,581; 3 years – includes 30% benefits), (ii) two 0.5 FTE Peer Support Workers to deliver the intervention, with both providing 50% of both brief and full versions of the WB to offset clinician effects(one at 69,167 in grant and one at 69,167 in-kind (core funded, CAMH), 2 years to allow for preparation, delivery, and wind down along with capacity building/KTE), and (iii) 4k for 35 hours of statistical consulting at $120/hour (Biostatistician). Peer Supports will carry caseloads of 4-6 participants each. Along with outreach travel, supply purchase, documentation, and assistance with recruitment (e.g., orienting teams, connecting with social workers) this workload aligns with our past experience with the intervention.

(Research Analyst 2, step 2, (Y1 29.27 + 30% bens 8.78 = 38.05 (.8fte, 10mos 45,660); Y2 29.71 + 30% bens 8.91 = 38.62 (.8fte 55,613); Y3 30.16 + 30% bens 9.05 = 39.21 (.8fte – minus 1 month, 51,789)
Peer Support Worker (Y1 27.08 + 30% bens 8.12 = 35.20, total 68,640; Y2 27.49 + 30% bens 8.25 = 35.74, total 69,693)

Trainees (Subtotal: 18,604)
One graduate student trainee will be engaged for 2.5 years of the project (7 hours/week; 19.38/hour – includes 13% benefits; 18,604 total) who will assist with data entry and management, data collection, and work closely with the PI and the Research Assistant. Deliverables for the graduate student will be 1 poster for which they will be first author and authorship on the core peer-reviewed publication.

Consumables (Subtotal: 10,265)
At $65/participant for WB intervention supplies, the total cost will be $8,625. Participants will be reimbursed $25/assessment (3 assessments/participant, 110 completers and 15 drop outs, total is $4,250). A total of $500 requested for general materials (printing, files, encrypted memory stick). A total of $1,140 is requested for transit tokens for outreach by Peers (estimated 350 trips/$3.25/trip).

Knowledge Translation (Subtotal: 4,500)
We are requesting $2500 to fund the open access publication of the main paper to come out of the study. We are requesting $2000 to cover the costs of the PI presenting the findings at an appropriate national or international meeting (estimated $500 flight, $50 per diem for 3 days, $250/night hotel, $200 taxi, $500 meeting registration).