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WHAT WORKS IN A NURSE LED SELF-MANAGEMENT PROGRAM FOR PATIENTS WITH SERIOUS MENTAL ILLNESS (SMI) AND DIABETES (DM)

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Abstract

Objective—To develop a deeper understanding of “*how*” a nurse led self-management intervention in a successful randomized controlled trial (RCT) for individuals with both serious mental illness (SMI) and diabetes (DM) influenced health outcomes and the lives of the participants.

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HUMAN SUBJECTS APPROVAL STATEMENT

The study was approved by the MetroHealth System Institutional Review Board (IRB), FW00003938, Protocol number 00000685.

CONFLICT OF INTEREST

Dr. Sajatovic has research grants from Pfizer, Merck, Janssen, Reuter Foundation, Woodruff Foundation, Reinberger Foundation, the National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC). Dr. Sajatovic is a consultant to Bracket, Prophase, Otsuka, Pfizer and Sunovion and has received royalties from Springer Press, Johns Hopkins University Press, Oxford Press, UpToDate, and Lexicomp. All other authors have no conflict of interest to report.

Methods—In depth interviews, were conducted with a sample of 10 participants who received the self-management intervention in the RCT. Interviews were audiotaped, transcribed verbatim, and analyzed using content analysis, with an emphasis on dominant themes.

Results—The mean age of the respondents was 53.9 years (SD=5.6); 6 (60%) were women and the mean level of education was 12.4 years (SD=2.4). Transcript based analysis generated 3 major mechanisms of action that led to improved self-management of their SMI and DM: (1) positive group experience, (2) increased health knowledge, and (3) increased self-confidence.

Conclusions—Developing complex interventions for testing in RCTs of individuals with SMI and other comorbid conditions is of increasing importance in healthcare planning for this vulnerable population. Using qualitative methods to explore mechanisms of action underlying quantitative outcomes, can enrich our understanding of processes relevant for individuals with SMI and comorbid conditions.

Keywords

serious mental illness; diabetes; self-management

INTRODUCTION

Adults with severe mental illness (SMI), such as schizophrenia and bipolar disorder are estimated to die, on average, 25 years earlier than the general population.¹ Much of the premature mortality among individuals with SMI is due to medical comorbidities, such as diabetes (DM) which is more common among people with SMI as compared to the general population.² This is facilitated by a variety of factors including sedentary life style, poor diet and the metabolotoxic effect of many psychotropic medications.^{2,3} The Institute of Medicine⁴ has called for improvements in health care for individuals with SMI and medical comorbidity. A recent review on integrated general medical and psychiatric self-management interventions in people with SMI suggest that they are effective in improving health outcomes.⁵ However, how best to implement self-management approaches is not entirely clear and self-management training is under-used in clinical settings.⁵ Qualitative research that elicits input from individuals with SMI and medical comorbidity may offer insight into the patient engagement component of self-management interventions and help with future scale-up.

The current investigators recently completed a prospective, 60-week, randomized controlled trial (RCT) that assessed *Targeted Training in Illness Management (TTIM)* vs. treatment as usual (TAU) in 200 individuals with SMI-DM. The TTIM intervention was led by a nurse educator who delivered a curriculum of content focused on enhancing self-management of SMI and comorbid DM. (Table 1). The nurse educator role was conceptualized as the TTIM “content expert.” To enhance program effectiveness, trained peer educators, patients with both SMI and DM, provided complementary support and structure as “experiential experts” in SMI and DM self-management. A characteristic feature of TTIM was having a nurse educator provide information on the “how-to” of self-management, which the peer educator could expand on in terms of barriers and facilitators to success. The interaction between nurse educators, peer educators and patients, was a key feature of the TTIM intervention.

The study was conducted in the primary care setting of a safety-net health system and evaluated effects on SMI symptoms, functioning, general health and DM control. As in the chronic disease/long term condition paradigm of disease management, TTIM stressed the self-management approach to SMI and DM. Psycho-education, problem identification/goal-setting, behavioral modeling, and care linkages, all emphasized the patient's central role in managing their chronic medical and mental illnesses.⁶⁻⁸

In step 1 of the TTIM intervention, 12 weekly group format educational sessions (Table 1) were delivered by a nurse educator, assisted by a peer educator. Sessions were also manualized and included hand-outs that reinforced the material delivered in the group sessions. In step 2, during the 48 weeks following the group sessions, participants had brief telephone maintenance sessions with the nurse educators. Telephone sessions occurred every other week for the first three months, and monthly thereafter. A more comprehensive description of the nurse's role in the TTIM intervention can be found elsewhere.⁹

Results of the study revealed a greater improvement at 60-weeks in TTIM vs. TAU in psychiatric illness severity ($p=.0008$), depression ($p=.0156$), functioning ($p=.0031$), and DM knowledge ($p<.0002$). While both TTIM and TAU groups had similar 60-week improvement in HbA1c (a biological marker of diabetes control), in a post-hoc analysis of the sub-set of patients with good to fair baseline HbA1c (more than 50% of the entire sample), TTIM participants had minimal HbA1c change over 60-weeks, compared to TAU who had worsening HbA1c. Of 84 participants who responded to a survey on TTIM acceptability, 98% ($N= 82$) strongly agreed or agreed that TTIM was useful to them. Most (95%, $N= 80$) strongly agreed or agreed that TTIM covered most of the important issues.¹⁰

While these quantitative results of the RCT provided information on whether the TTIM intervention had an influence on patient health outcomes, we went beyond the question "*Can the intervention influence outcomes?*" to ask questions from the patients' perspective: "*How* did the intervention influence outcomes and *how* did it influence the lives of the study participants?" In the following qualitative analysis we describe patients' responses to these two questions and discuss how our findings can inform and enrich our understanding of the processes that impact the outcomes of this RCT and how these insights may help inform future work in chronic illness management among people with SMI.

METHODS

Sample and Setting

Participants ($N=10$) from the RCT, who participated in the TTIM arm of the study, were recruited for the present qualitative study. For qualitative research, this sample size is within the recommended number of 5–25 individuals who have all experienced the same phenomena.¹¹ Inclusion criteria included having schizophrenia, schizoaffective disorder, bipolar disorder or major depressive disorder confirmed by the Mini-International Neuropsychiatric Interview (MINI),¹² having Type 2 DM, being age 18, being able to communicate in English, and being able to provide written, informed consent. A sampling grid designed to ensure variability in psychiatric diagnosis, gender, age, and race/ethnicity, was used in the recruitment of these 10 TTIM participants. The study was approved by the

Institutional Review Board of the participating institution. All participants provided written informed consent.

The mean age of the respondents was 53.9 years (SD=5.6); 6 (60%) were women and the mean level of education was 12.4 years (SD=2.4). Four (40%) identified themselves as African-American, 4 (40%) as Caucasian, and 2 (10%) as Hispanic. Eight (80%) had major depression, 1 (10%) had schizophrenia or schizoaffective disorder, and 1 (10%) had bipolar disorder. The mean duration of SMI was 20.2 years (SD=13.4) and the mean duration of DM was 11.5 years (SD=9.3).

Study Design

In this cross-sectional qualitative study, a thematic analytical approach was used to develop a deeper understanding of how the intervention influenced quantitative outcomes and how it influenced the lives of the study participants.¹³ In this approach researchers move their analysis from a broad reading of the data towards discovering patterns and developing themes.

Qualitative Data Collection and Analysis

Qualitative methods, consisting of focused in-depth interviews, with 10 participants in the TTIM intervention group, were used to elicit responses about their perceptions of the intervention at the 13th-week follow-up point of the trial. In in-depth interviews, the goal is to explore a topic more openly, and to allow interviewees to express their opinions and ideas in their own words.¹⁴ Therefore, participants were given as much latitude as possible to describe their lived experience of being part of this study. A topic guide was used to focus the discussion on main topics, and specific topic-related questions. For example, under the topic, “how the TTIM program influenced outcomes,” the following question was asked: *“Can you tell me what it was like to be in the TTIM program?”* Under the topic “how the TTIM intervention influenced the lives of the study participants,” we asked: *“Since being in the TTIM program, what is it like for you having to self-manage two illnesses like SMI and DM?”* Follow-up questions such as *“Would you explain further,”* and *“Would you give me an example?”* were used to facilitate respondent communication. The interventionists (nurse and peer educators) were also interviewed to explore, from their perspectives, the processes and dynamics that took place during the sessions. Interviews, which lasted approximately an hour, were audiotaped and transcribed verbatim. All personal identifiers were removed from the final transcripts.

We used a grounded theory approach to data analysis, encompassing open, axial and sequential coding, and the constant comparative method to generate constructs (themes) and elaborate the relationship among them.^{13,15} A coding dictionary that included mutually exclusive code definitions was then constructed. Coding structure was reviewed after a preliminary analysis of a sub-sample of transcripts, and the dictionary was refined through comparison, categorization and discussion of each code’s properties and dimensions.^{13,15} Two qualitatively trained investigators independently coded each transcript to ensure consistency and transparency of the coding; discrepancies were resolved by discussion. To

further enhance analytic rigor, an audit trail (researchers' analysis, notes, minutes of researchers' meetings) was performed throughout the research process.¹⁶

RESULTS

How the Intervention Influenced Outcomes

As presented in Table 2, analysis of the data revealed that the chief perceptions of the "mechanisms of action" of TTIM appeared to be positive group experience, increased health knowledge, and increased self-confidence. These mechanisms translated into improved self-management of their SMI and DM.

Positive Group Experience—Initially, respondents felt anxious about participating in a group format where they might be judged by others:

"Well, when I first started, I felt a little nervous of course. But I was just worried about being honest about myself because I think that more or less I was worried about what other people would think about me. But after a few meetings, I started meeting the people and I just said, you know, I'm here to get better, period. And I just started opening up and I just, I got, I guess I could say, I was more open minded and opening my ears to listen to other people and actually I got a lot of pointers from them for myself too." Respondent #20

"It felt good to be in a group that people didn't judge you. They helped you. They didn't judge me, 'cause I told them I smoke pot, they didn't judge me for that. Respondent #330

Sharing their own stories and experiences about living with SMI and DM, and feedback from others, reduced feelings of loneliness, isolation, alienation, and facilitated learning:

"You know, when they talk about what you have and what they have, you learn that you're not the only one, you know, that's going through this." Respondent #209

"Being around people that were further off into diabetes as well as depression as well as other illnesses that I knew about; but now I'm sitting next to that type of person. And I see that that type of person can function just like anyone else. Certain things they can't do, 'cause there's certain things I can't do. And I understand that the person over here whose sitting down, and literally they can't walk. They walk with a cane, but they were there at this meeting to tell us as a class about how their life has been since they've been in the situation. So I learned from them. It was all learning. And I didn't even know them. I never had seen any of them in the class in my life, and I learned a lot from them." Respondent #522

Group Process—The nurse educators described the group process as dynamic and empowering:

"Oh my gosh, I just think it was wonderful to see the dynamics in terms of how the group came together! I think the group dynamics were very empowering for issues or concerns that would arise; how intuitive the group was in terms of being able to pick up on those and meet other participants where they were at in terms of the

process. The dynamics were really such that everybody felt comfortable.” Nurse Educator #1

“It was so exciting when after probably about the third class in, people really had bonded with each other and when I saw some of the patients who had been quiet, who’d been a little reserved opening up and especially when we did the role playing, and the one patient used the word empowerment. I just about jumped out of my seat. It’s just a wonderful thing for an educator to feel that they’ve actually empowered somebody, especially these patients who because of the stigma of mental illness, have socially isolated themselves a little bit, you know, they don’t open up too much. So it was a wonderful thing!” Nurse Educator #2

Having a peer educator in the group share his/her own stories of trying (and sometimes failing) to manage their own SMI and DM, was an important factor in helping to facilitate discussion and promoting group cohesiveness:

“We’re not supposed to act like we’re the authority or give advice. We don’t give advice about what you should or not do about such and such. We can talk about what we went through and that it’s possible to do things better and different. We have a disease and we get it treated!” Peer Educator# 4

Increased Health Knowledge—A variety of resources and approaches to disseminate health information to TTIM participants during the group sessions facilitated nurse educator flexibility in meeting participants’ learning needs. These included the use of a standardized TTIM manual which reinforced the material covered in each of the 12 sessions:

“They prepare you a manual with information that explains what the medicines do, what each medicine is for. And also food portions and which foods are more high in carbs. Which foods are not so good to get out of a sugar low, because if you eat something fatty that’s not going to go through your blood stream right away. You’ve got to eat something high in carbs. Like the best is orange juice, natural orange juice, gets you out of a low. The information was very helpful. #83

“The manual is like my bible. I was reading that the other night. I keep going over it and over it; there are so many things in there ! Well, basically I guess that I keep reading it because then I keep it in my mind and I keep my emotions in control so that I don’t get all excited. It helps me!” Respondent #20

As well as using practical approaches to reinforce learning about managing their illnesses and how to solve problems:

“Well one of the biggest problems I had was my diet. Even after I knew that I was a diabetic, I didn’t really know what a carb was, how to count them. But in TTIM the nurse was giving you real life examples like we learned to look at a menu and to read a label. Those were the important things, and now I feel comfortable whereas before, I just threw up my hands or not eating at all.” Respondent #578

One of the big things for me was learning how to attack a problem. You know first to admit that there is something and then you go about solving it, I know there was an acronym for that, **SMART**, which meant is the problem **S**pecific, **M**easurable,

Achievable, Realistic, and can you do it in a certain Timeframe. That helped a lot. The week we went over that it was like an eye opener. You know, you just approach whatever the problem is in certain steps and it just doesn't seem so big to solve, you know, you break it down and ... "Oh, that was easy!" After you had the knowledge, it was easy. Respondent #212

Most importantly, participants now understood that there is a relationship between SMI and DM, and that one co-morbid condition can affect the other:

"I learned that there is a relationship between serious mental illness and diabetes; that they have an effect on each other; that the management of drugs needs to be of equal importance. And I think for the longest time I focused on mental illness, because it had given me the most problems, got priority always. And now it's like, no, this (diabetes) is as important; being med compliant, measuring your blood sugar, doing all the pieces that have to do with being a responsible diabetic are not unlike those things that I have to do with being a responsible bipolar person. But one does not outrank the other. But it's finally made my diabetes management as important as management of my mental illness". Respondent #455

Increased Self-Confidence—Participants clearly felt that the ability to share and learn from others in their group sessions increased their self-confidence about being able to manage their SMI and DM:

"Well for increasing my confidence, it's just talking with people in the group. I mean, obviously it's something that you can relate to! I mean this is people experiencing what you are; you can relate to them. I mean, I think two people with the same problems, they could relate to each other better than you go and talk to a doctor! I don't know why that is, but it's just something that builds definitely my confidence. I can't explain what it does to me, but it's a wonderful thing!" Respondent #20

The follow-up calls by nurse educators continued to promote self-confidence in the respondents' ability to keep on track with their self-management goals:

"When the actual classes ended, also the nurse called me, asking me how I was doing, how was I meeting my goals for the month; you know, stuff like that. It helped, because, again, you're your own enemy. You're the one that's lax before you get that call. And even if you don't say much, just that call tells you, 'hey', you've got to keep on track". Respondent #83

In summary, participants identified positive group experience, increase in health knowledge, and increased self-confidence, as the mechanisms of action that led to improved self-management of their two co-morbid conditions.

How the Intervention Influenced the Lives of the Study Participants

Many informants felt that they were now more accepting of having SMI and DM:

"Yes. I accept that I was born with it (SMI), and, it ain't no cure for it, just a way you can manage it. Respondent #578

And felt that their participation in TTIM led to improved self-management skills such as attention to diet and checking for emotional triggers:

“I’ve been looking at my labels. When I go to the stores I always go looking at the labels, I look at the stuff and be checking all the time. When I see something good I be like looking at the label and I’m like, “oops, I can’t take that!” Respondent #209

I’m checking my sugars more. I’m eating more, healthier. I’m watching for my emotional triggers, or stuff that’s not in my control. Respondent #330

As well as exercising and setting a schedule for medications and sleep:

“Like S (the nurse educator) told us, if we exercise our blood sugar will go down, and she was right!. And I start to exercise and my blood sugar did go down!”

Respondent #578

“Because I exercise and went from 263 pounds, now I’m only 241 pounds.

Respondent #255

“Setting a set schedule, which I didn’t have before TTIM. I mean, my medicine, I would take it at 8 o’clock, 9 o’clock, 10 o’clock, whenever, I would remember, you know, something like that. Now I try to take it at one set time. I try to keep a schedule not only for my medicine, but also for myself as far as going to bed.”

Respondent #212

Other self-management skills learned in TTIM, led to increased communication with their physicians and a decrease in the social isolation brought on by SMI:

“I now know how to address the problem of communicating better with my psychiatrist. I practiced what I learned in TTIM and was able to tell him ‘I have a problem with this medication; I have these difficulties with the side effects; I have this difficulty with keeping it on schedule, can we talk about this? I never would have had that conversation with my prescribing psychiatrist had I not been in an active discussion in TTIM classes, for instance, talking about problem solving and what are different methods of doing that.” Respondent #455

“Getting out of the house for the depression; trying to be out. I try to meet with some of my neighbors every evening or six nights a week. I was thinking about doing this ambassador program where what they do is walk a couple of blocks every day.” Respondent #83

In summary, participants identified the following newly acquired self-management skills as helping them to deal with their comorbid SMI and DM: acceptance of illness, attention to diet, exercising, scheduling medications, improved communication with healthcare provider, checking for emotional triggers, and decreased social isolation. The impact of the TTIM program on the present lives of the participants can best be summarized as follows:

“It undersells it to say that it was an educational experience, but it was really a kind of awakening for me! It was quite a surprise to discover that the things I already thought that I knew were not being put into practice up till now!” Respondent #455

DISCUSSION

When complex interventions are administered in RCT's, it is difficult to determine precisely what factor(s) are responsible for the outcomes of the RCT. Where quantitative results can demonstrate that a teaching intervention leads to better control of a disease, qualitative research can provide an explanation of "why" and "how" it does.¹⁷ Eliciting meanings from the subject's point of view rather than from that of the researcher approaches the phenomena of interest by considering and including the important underlying values and context.^{14,17} To the best of our knowledge, this is the first reported qualitative study to identify inductively the perceived mechanisms of action of a successful self-management program for individuals with both SMI and DM.

Several observations about the data deserve mention. First, participants in TTIM identified positive group experience, increased health knowledge, and increased self-confidence, as the mechanisms of action that led to improved self-management of their two co-morbid conditions. These findings are consistent with social cognitive theory which posits that individuals learn by observing others and behave in specific ways to reach goals.¹⁸ This theory also suggests that knowledge, self-efficacy, and outcome expectancy are important precursors to behavioral change, and effective modeling can teach coping strategies for a variety of situations.¹⁹ The positive group experience reported by participants in TTIM provided the opportunity to give information as well as gain information from others, helped them improve their health knowledge about SMI and DM, increased their self-confidence, and improve their self-management skills. It has been noted that interventions that include regular reinforcement in a group setting, are more effective than a single educational session.²⁰

Group sessions also provided participants a method of social engagement and support that they lacked in their every-day life. Social support has been found to be important in improving chronic disease self-management, fostering engagement in SMI treatment, and improving adherence to medical advice among persons with DM.²¹⁻²³ The addition of peer educators, who had both SMI and DM, into the group, also provided social support and helped to facilitate engagement and learning by sharing their own experiences as persons who have struggled with the same issues. A person who has "been there" can offer empathy, reassurance and affirmation of the shared human struggle with illness, and provide motivation to persist in healthy behaviors.^{24, 25}

Individuals with SMI and DM often feel isolated and marginalized because they are unaware of the wide prevalence of SMI and DM and know few individuals who effectively manage these serious comorbid conditions. Additionally, people may be reluctant to talk about their SMI in standard medical settings where time is tight and clinicians may have a poor understanding of SMI. The TTIM group sessions with others who had SMI, helped to normalize and de-stigmatize mental health and substance abuse issues for the participants. Group participants now felt that they were not alone in the isolation and loneliness imposed by their SMI. The positive and supportive group experience reported by the participants in this study might be why TTIM seemed to have had its strongest effects on mental health outcomes in the RCT.

Second, a key feature of TTIM is that it addresses both mental and physical health concurrently and promotes a holistic appreciation of self that includes both mind and body. Our findings revealed that the participants who completed the TTIM program now understood that one comorbid condition can critically affect the other. Rather than treating their SMI and DM as two separate disorders, TTIM empowered individuals to think holistically about their health. Given the growing recognition of the synergistic negative effects of DM and SMI²⁶, it is critical that individuals with these comorbidities receive treatment that addresses both of these issues concurrently.²⁷

There are some limitations to our study. Patients with SMI and DM who receive care in other treatment settings, or those who have less severe or disabling illness, may have different experiences in managing these chronic illnesses, and different types of encounters with providers and healthcare systems. The small convenience sample and the conduct of the study in a single urban area in the U.S. may limit transferability of the study findings. These limitations are offset, to some extent, by the use of rigorous qualitative research methods described in this study and our use of the Consolidated Criteria for Reporting Qualitative research (COREQ).²⁸ The self-report method is direct, versatile, and yields information that would be difficult, if not impossible, to gather by other means.

CONCLUSIONS

Our qualitative findings from an RCT allowed us to understand more fully how the social and educational processes provided by the TTIM intervention provided an opportunity for individuals with both SMI and DM to exchange support with others facing similar challenges to self-management, to learn from each other as experts in their own disease, and to improve their present lives. Our findings are consistent with a recent chronic disease self-management study which found that the outcomes of the program depended on the complex interplay of four social factors. These included social engagement, the development of a collective identity, the process of building collaborative coping capacity, and the establishment of exchange relationships.²⁹

Developing complex interventions for testing in RCTs of individuals with SMI and other comorbid conditions is of increasing importance in healthcare planning for this vulnerable population. Qualitative results from this RCT indicate that a nurse led active illness self-management approach, such as TTIM, taps into the power of patients to improve their health and is crucial in minimizing the morbidity and mortality associated with having SMI and DM. Group-format approaches may be particularly fruitful with respect to patient empowerment, while at the same time combatting stigma and social isolation so prevalent among people with SMI. Future RCTs that use qualitative methods to explore mechanisms of action underlying the quantitative outcomes, can enrich our understanding of processes that are personally salient for individuals with SMI and comorbid physical conditions and may inform integration of these factors into care delivery practices.

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Table 1

Topics and Health Behaviors Covered in in the 12-week TTIM Intervention Sessions with Patients

Session	Topic(s)
1	Orientation and introductions, Emphasize ground rules, Establishment of a therapeutic relationship, Discuss facts and misconceptions about SMI, An introduction to DM
2	The challenge of having both SMI and DM, Stigma of SMI and strategies to cope with stigma, Relationship of SMI symptoms and functioning in response to stress and DM, An introduction to personal goal-setting
3	Personal SMI profile (what does worsening illness look like for you), Triggers of SMI relapse, Personal action plan for coping with SMI relapse
4	Diabetes complications and benefits of change, Blood sugar monitoring, Symptoms of high/low
5	Problem-solving skills and the IDEA approach (Identify the problem, Define possible solutions, Evaluate the solutions, Act on the best solution), Talking with your medical and your mental health care providers, Role play of communication with care providers
6	Nutrition for best physical and emotional health, Reading labels
7	Replacing unhealthy sugar and fat, Substance use and its effects on SMI and on DM, Problem-solving to feed your body healthfully
8	Effects of exercise on physical and emotional health, The importance of daily routine and good sleep habits
9	Medications and psychological treatments for SMI, A personal care plan to take care of the mind & body
10	Social supports and using your available supports, Types of physical activity and your community
11	Taking care of your feet, Staying on track with medication treatments
12	Illness management as a life-style, Acknowledgement of group progress, Setting the stage for ongoing Illness management and recovery

Table 2

Mechanisms of Action of TTIM

Themes and Categories	Illustrative Quotations from Respondents (N=10)
Positive Group Experience	<p><i>"Everybody got along. Everybody accepted each other very good." Respondent #578</i></p> <p><i>"Actually, it was very, very comfortable to be in that program on the strength that there were people just like me that had the symptoms. One of them had the symptoms like me, and here I was in denial and scared to reveal it and here they just blurted it out. And I'm looking at them like uh, you really trust this person? The more I came, the more my trust issues got to be smaller. I only missed one class, that's when the lights went out." Respondent #256</i></p>
Increased Health Knowledge	<p><i>"When we were talking about food choices, we had the divided plate, and this is the green and the crunchy vegetables, and this is the protein, and this is a starchy veggie. And this was a way to put your plate together. And I thought, this is so simple and this makes such good sense. When I started doing that as a regular way that I put a plate full of food for meal time together, it just worked better. And among other things, it usually eliminated the need for dessert, because this whole idea, the crunchy vegetables you can go back as many times as you want. The idea that there was still something that you could do that was unlimited was wonderful. Respondent #455</i></p> <p><i>"The TTIM program because I learned more about the connection of diabetes and mental illness. You know I didn't realize there was that much of a connection, but now I know there is because of what I went through with class." Respondent #26</i></p>
Increased Self-Confidence	<p><i>"You know what? I have great confidence now, 'cause I know somebody is backing me. I didn't have that before. Usually its Christmas, I usually be down. I'm not down, you know, I'm just thankful to be here. You know, little things people have done through this whole year had made this day possible. I'm serious, totally serious. Respondent #256</i></p>