

Nebraska Division of Behavioral Health
OCA People's Council Meeting
March 27, 2014 9:00 am -2:30pm
Region V Large Conference Room
1645 N Street Lincoln, Ne

DRAFT Meeting Minutes

I. Call to order and roll call **Judie Moorehouse**

Chairperson, Judie Moorehouse called the meeting to order at 9:00 am on March 27, 2014. Roll call was conducted and quorum determined.

Council members present: Nancy Rippen, Mary Thunker, Jennifer Ihle, Judie Moorehouse, Tammy Fiala, Ryan Kaufman, Lisa Casullo , Candy Kennedy- Goergen

DHHS Staff present: Carol Coussons de Reyes, Maya Chilese, Cynthia Harris, & Lucy Flores

Public present: Ken Timmerman, & Marlene Sorenson

II. Housekeeping and summary of agenda **Carol Coussons De Reyes**

Carol confirmed the order of the agenda; **Handout A:** Agenda noting one change...Mark Dekraai would be attending the meeting at 10:00 am and not at 9:30am. Carol handed out **Handout B: Information on HIPPA with an additional note not to have a Social Security Numbers listed.** **Handout C: Handout** on By-laws was distributed by Carol and discussion on section (L) Members may be on the council for 2 years, as long as 3 consecutive meetings are NOT missed. Roll call was taken by Carol on membership on amending the By-laws to be taken into effect on March 27, 2014. A motion to vote on the by-laws amended by Mary Thunker and seconded by Nancy Rippen. The motion was approved by unanimous vote.

III. Approval of minutes **Judie Moorehouse**

A motion to approve the minutes for August 6, 2014 was made by Candy Kennedy - Goergen The motion was seconded by Mary Thunker. With the correction of Ryan Kaufman's name. The motion was approved by unanimous vote.

IV. Public comment **No Public Comments**

There was no public comments.

V. Nebraska's Transformation Transfer Initiative: **Mark Dekraai**

Mark was introduced by Carol. Mark reported on **Handouts D, E, & F**, **Handout D:** Nebraska's Transformation Transfer Initiative: **Handout E:** Nebraska Peer Support Certification Study: & **Handout F:** Nebraska Peer Support Focus Group/ Survey Report: Mark Reviewed TTI, Peer Support Survey, and Public Policy Center Recommendations. Carol resumed discussion on TTI report with comments or concerns on the report and opened to any questions.

VI. Nebraska Certified Peer Specialists Conference Update & Peer Network Ken Timmerman

Ken and Judie gave updates on peer Network. Last year's conference was a huge success. The planning committee met a couple months ago confirming the next conference will be held in September 21-22, 2014 in Grand Island. The conference will have scholarships once again with approximately 100 open. The planning committee is working on getting speakers and having workshops involving around peer support certification and family peer support. Networking- peer networking where peers talk to each other on what's out there. Once again Amy Beacon is helping and can expand on networking. Workshops can work on how to enhance peer support and some certified not to be exclusive. Along with social media to connect with one another, do newsletter, involve face book & face camp for employment and education. Face book conversation for providers to know and post it on the site and the website can subscribe OCA jobs available on links. There is a job site for Workforce Development not just nationally, but for Nebraska.

VII. Report on what Recovery Measures Regions Use, if any Regional Consumers Specialists

Carol asked Regional Consumer Specialists how recovery was measured in their regions, if any. Several of the RCS responded: Region 3, Tammy indicated measures; to survey with partners on recovery focus with satisfied formulas. Region 2, Nancy surveyed annually measures and recovery met their demands. Region 1, Judie- RSA recommended to regions. Candy, comments to use tools state wide measurements recovery survey for provider and to have your own. Tammy, Meet with consumers on survey/questions, also consumer satisfaction measured interaction; Was Certified Peer Support Wellness Specialists a good fit for you? Other comments on measurements were on doing phone surveys; implementing the RSA to regions and that the council do a recommendation to the state about MHRM; Health screening –nurse's visiting Nurses Association. Regional Consumer Specialists noted interest in a project related to the RSA.

VIII. Family Peer Support ; Candy Kennedy- Goergen

Candy presented a presentation on Family Peer Support: **Handout G:** Certification of Parent Support Providers, **Handout H:** Working Definition of Family –Driven Care **Handout I:** What does it take to prepare families and support them to be involved in larger issues, more than their own, community and or system involvement. What do you think it takes to help the providers, to encourage this level of involvement in Family Driven Care? Are there things the system could do to advance Family Driven Care? If so what?

IX. Veterans Support Marlene Sorenson

Marlene gave a presentation on **Handout J** VA Peer Support the Road to Recovery: Marlene gave an introduction of her VA position and as a Peer Support: Peer support is help given to those in need by another who has gone through a similar trauma or challenge, and Peer support is learning from someone who has been there and done that. Reviewed VA Peer Support the Road to Recovery.

X. Hear from New Applicants Carol Coussons De Reyes

Ryan Kaufman and Lisa Casullo introduced themselves to the Office of Consumer Affairs People's Council. Welcome Lisa and Ryan.

XI. Meeting Adjourn

Judie Moorehouse

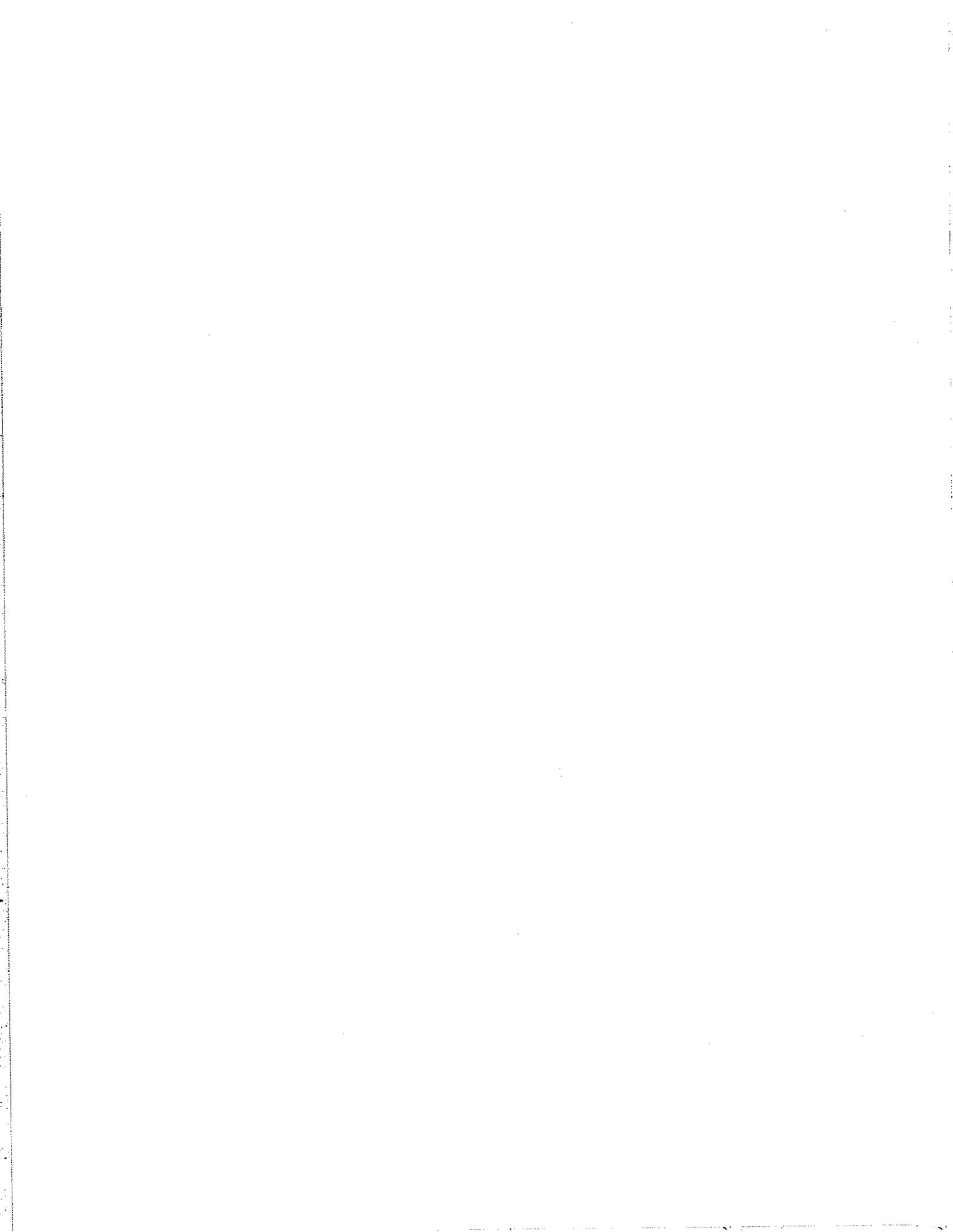
Meeting adjourned due to lack of quorum to continue the meeting. Meeting was adjourned at 2:30 pm.

XII. Adjournment and next meeting

- Meeting adjourned March 27, 2014 at 2:30 pm.
- Next Meeting is scheduled for May 6, 2014 @ 9:00am – 3:00 pm.

Minutes prepared by the Division of Behavioral Health, Nebraska Department of Human Services. Minutes are intended to provide only a general summary of the proceedings.

3/27/2014 Meeting Minutes



A

Nebraska Department of Health and Human Services

Division of Behavioral Health

Office of Consumer Affairs

OCA People's Council

DRAFT Agenda

Region V

First floor Conference Room 1

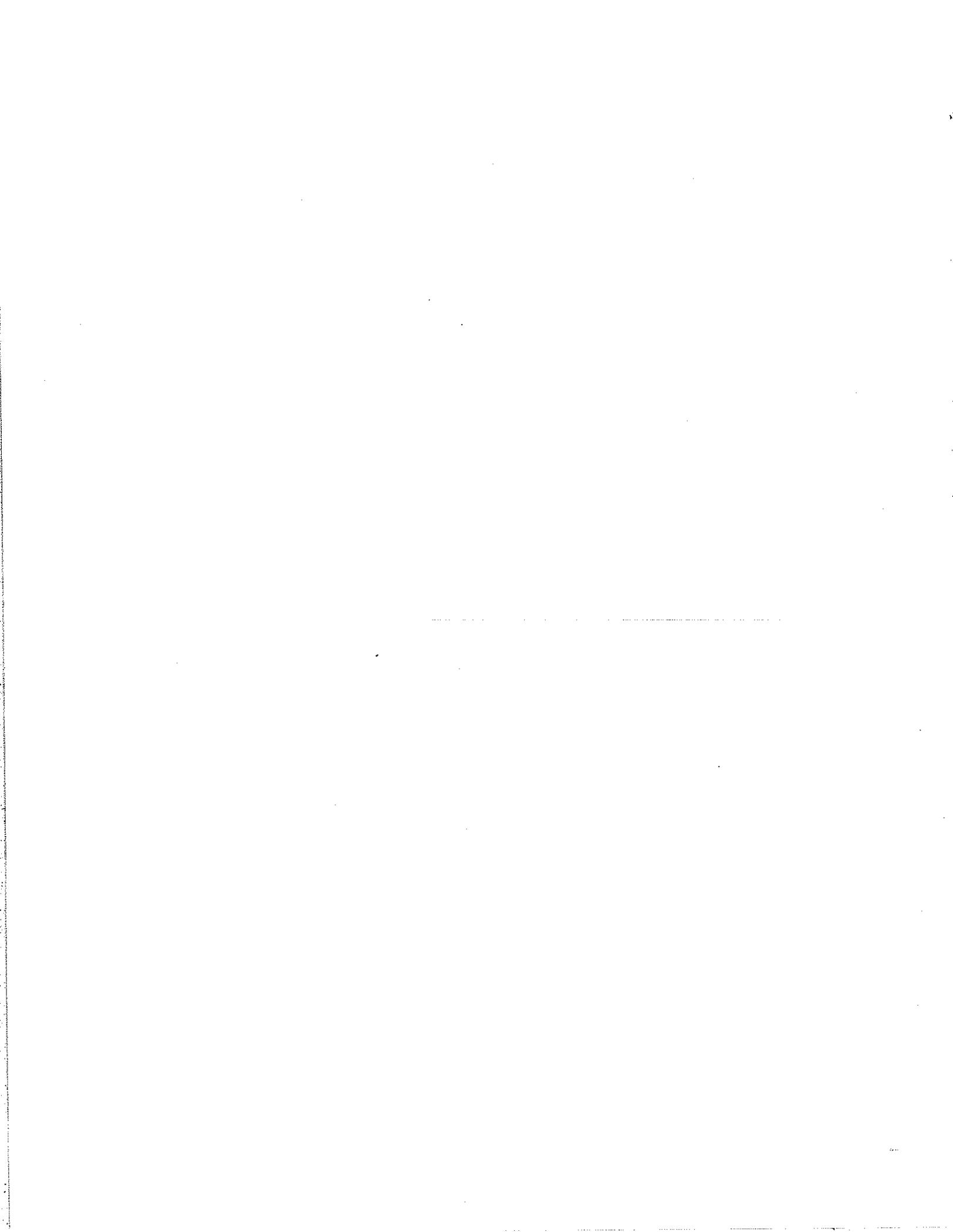
1645 N Street

Lincoln, NE 68508

March, 27, 2014

9:00am- 3:15pm

| | | |
|--|--|-----------------|
| Council Members | Agenda, Minutes Approval, Upcoming Events | 9:00am- 9:30am |
| Mark Dekraai | TTI | 9:30am-10:00am |
| Break | | 10:00am-10:10am |
| Mark Dekraai | Peer Support Survey | 10:10am-10:40am |
| Mark Dekraai | Public Policy Center Recommendations | 10:40am-11:10am |
| Break | | 11:10am-11:20am |
| Ken Timmerman | Nebraska Certified Peer Specialists Conference Update & Peer Network | 11:20am-11:50am |
| Lunch | | 11:50am-12:50pm |
| Regional Consumer Specialists | Report on What Recovery Measure Regions Use, if any | 12:50pm-1:20pm |
| Candy Kennedy- Goergen | Family Peer Support | 1:20pm-1:50pm |
| Break | | 1:50pm-2:00pm |
| Marlene Sorenson | Veterans Support | 2:00pm-2:30pm |
| Carol | Hear from New Applicants | 2:30pm-2:45pm |
| Public Comment | | 2:45pm-3:00pm |
| Judie Moorehouse | Adjourn | 3:00pm-3:15pm |





FOR
INFORMATION
B

Nebraska Department of Health
and Human Services

Authorization for the Disclosure of Protected Health Information

It has been explained that failure to sign this form will not affect treatment, or payment, however it may affect enrollment, or eligibility for certain benefits, provided per Nebraska Department of Health and Human Services. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me.

| | | |
|---|--------------------|---|
| Client Name (Last, First, M.I.) | | Date of Birth |
| Social Security Number | Case/ Chart Number | Period Covered Admission of: <i>People's Council Membership Term</i> |
| Information will be disclosed to: (Name, Address, City, State, Zip) <i>DHHS - Lincoln, NE 301 Centennial Mall South, 68509</i> | | Reason for Disclosure: <input type="checkbox"/> Eligibility Determination <input type="checkbox"/> Request of Subject Individual <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Legal Purposes <input type="checkbox"/> Consultation and/or Treatment Planning <input checked="" type="checkbox"/> Other (Please Specify) <i>OCA People's Council website listing with name.</i> |
| The information to be released pursuant to this authorization is limited to records/information from or in the possession of the following: | | |

Specific Information to be disclosed:

- | | |
|---|--|
| <input type="checkbox"/> Medications | <input type="checkbox"/> History & Physical Examination |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Psychiatric History & Treatment | <input type="checkbox"/> Aftercare Referral Form |
| <input type="checkbox"/> Psychological Evaluation & Treatment | <input type="checkbox"/> HIV Information |
| <input type="checkbox"/> Social History | <input checked="" type="checkbox"/> Other (be specific) <i>Name as Representative of OCA People's Council Member</i> |
| <input type="checkbox"/> Drug/Alcohol Information | |

This Authorization (unless revoked earlier in writing) shall terminate on (must have date or event filled in) *N/A*. By Signing this authorization, I acknowledge that the information to be released MAY INCLUDE material that is protected by Federal law and that is applicable to EITHER Drug/Alcohol or HIV related information or BOTH. My signature authorizes release of all such information. I also understand this authorization may be revoked at any time by submitting a written request in accordance with the Notice of Privacy Practices the Nebraska Department of Health and Human Services, published September 23, 2013 and it will be honored with the exception of information that has already been released. I also understand that if the person(s)/organizations authorized to receive my PHI is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

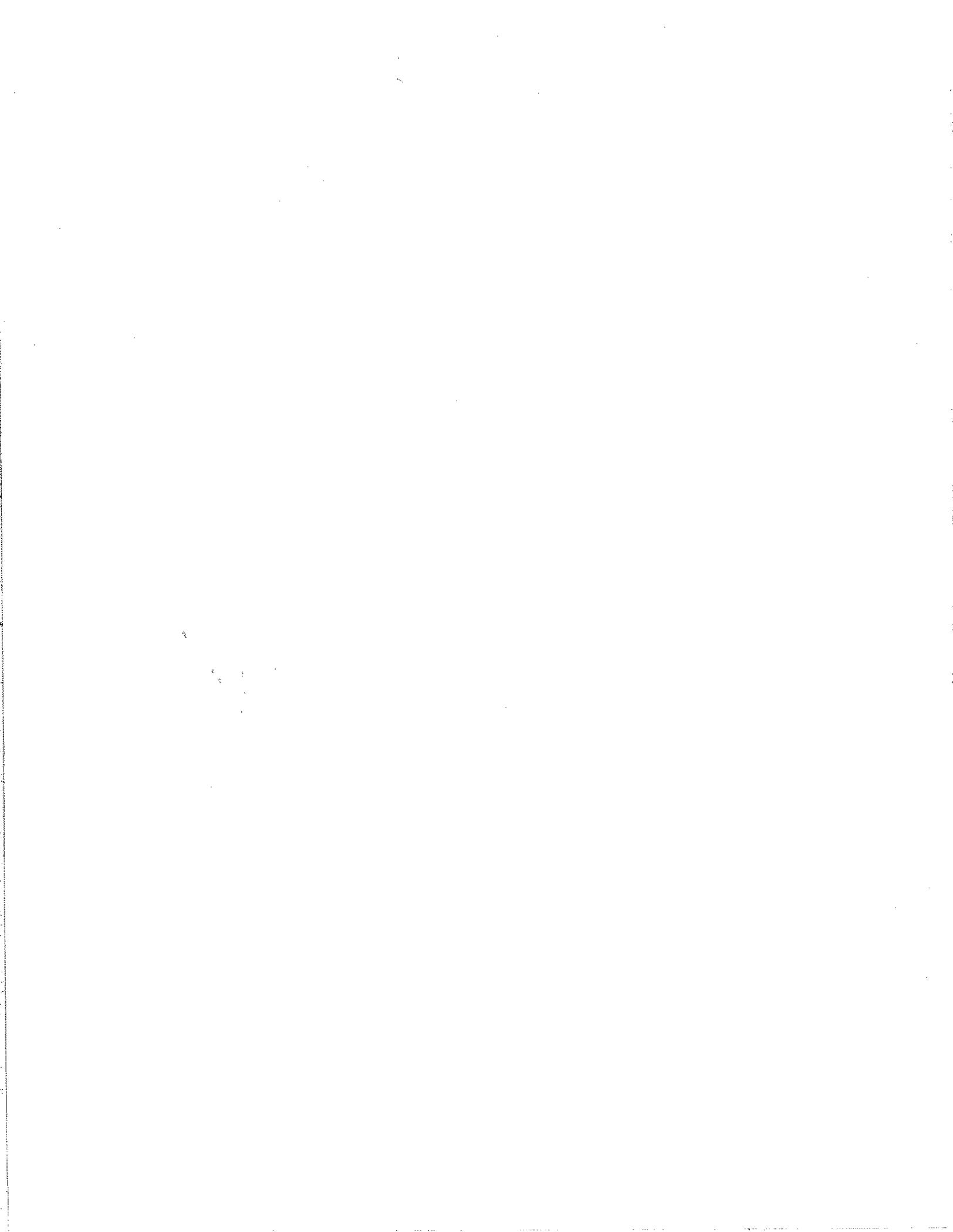
Client's Signature _____ Date _____

Personal Representative (Parent, Guardian, Power of Attorney) _____ Date _____

Witness's Signature _____ Date _____

NOTICE TO RECIPIENT

This information has been disclosed to you from records whose confidentiality is protected by state and federal laws (to include Federal Regulations, 42 CFR Part 2 of 1983) which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.



C

DRAFT: The OCA's People's Council- State Level Consumer Involvement Advisory Coalition

Mission

To inform the policies, planning, and procedures of the Office of Consumer Affairs

Vision

To present the statewide consumer voice in all matters before the council

Charge or Assignment:

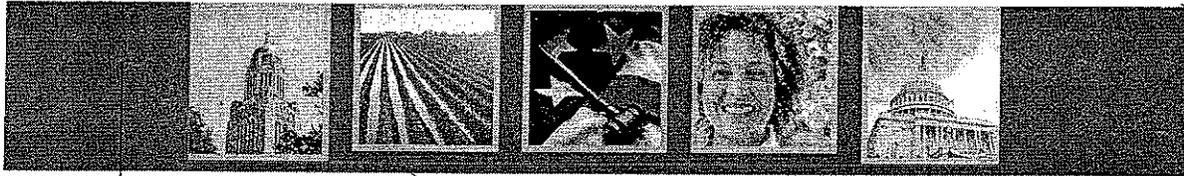
To advise the OCA on matters that relate to:

- a) The OCA, primary, and through its Administrator inform the Director and the Division on important behavioral health system matters. This does not remove the OCA from making its own executive decisions, but advice is greatly needed and appreciated.
- b) OCA Funding and Allocations (and related grants/contracts); statewide funding decisions
- c) Policy Development/Program Implementation
- d) Needs Assessments/Evaluations
- e) Outreach to Community via Education
- f) Ethics and Civil Rights related to policy, but not consumer complaints
- g) Early Intervention/Prevention Strategies
- h) Consumer Satisfaction/Rating of Services/Assessment of Community Integration
- i) Peer Specialist Training and Certification Programs
- j) Strategic Planning

Charter:

- a) The People's Council will convene every quarter.
- b) Members may not miss more than 2 consecutive meetings or they will no longer be considered members.
- c) Membership will attempt to include representation from each region
- d) All meetings are open to the public and will be advertised on the OCA website.
- e) A meeting must include at least a quorum (half active members) to continue.
- f) Meetings minutes will be recorded by a member of the OCA.

- g) The group serves at the pleasure of the director and may be disbanded after discussion with the council.
- h) There will be a chair and a vice chair to organize the meeting agenda.
- i) The chair and vice chair determined by vote of the council annually.
- j) Applications for membership will be collected by the Office of Consumer Affairs.
- k) After the first council is established, voting will be based on members present.
- l) Members may be on the council for 2 years, as long as they do not miss 3 consecutive meetings. If three consecutive meetings are missed, it will be two years before the seat can be replaced with that member and it will be filled by another applicant.
- m) Where there are two Regional Consumer Specialists employed in a Region, there will be one vote shared so that there can be more members to the council.
- n) Content for meetings will draw from the mental health and substance abuse.
- o) The Administrator of the OCA or his/her designee shall serve as staff to the committee.
- p) The following members will serve in 'ex-officio' status: 6 Voting Regional Consumer Specialists, 1 Voting Consumer and/or Family Representative of a Managed Care Organization, 1 Voting Nebraska Federation of Families Representative, 1 Voting Consumer Representative with BHECN, 1 Voting Consumer Representative of State Psychiatric Facility



Nebraska's Transformation Transfer Initiative:

2/4/2014

University of Nebraska
Public Policy Center
Mark DeKraai



Transformation Transfer Initiative

- Peer Support Facilitator Training
 - Vicarious Trauma/Compassion Fatigue Training
 - Trauma Across the Lifespan Conference
 - Trauma Literature Review
 - Peer Support Survey
 - Peer Support Focus Groups
-

NE IPS Facilitator Training

- Trainers: Chyrell Bellamy, Chris Hanson, Steven Morgan, Paige Hruza, Susan Hancock
 - August 26-30, 2013
 - Region 6 Offices - Omaha
 - 10 Participants
-

NE IPS Facilitator Training

- Principles and core skills of adult education
 - Overview of the stages and practices of group work
 - History of the Consumer/Survivor/Peer Movement
 - The mechanics of facilitation, training and education
 - The principles, practices and skills of Intentional Peer Support (IPS)
 - The principles, philosophy and practice of person-centered planning
 - Dealing with difficult situations
 - Working in the mental health system
 - Self and Relational Care
-

Compassion Fatigue/Vicarious Trauma Training

- Kay Glidden & Beth Reynolds
- Purpose: Understand signs of compassion fatigue/vicarious trauma/burnout and tools for combatting
- August 16, 2013
- 22 Participants

Compassion Fatigue/Vicarious Trauma Training

| | |
|---|-------------|
| Quality/Relevance of Information | 3.82 |
| Organization | 3.64 |
| Presenters | 3.88 |
| Materials | 3.64 |
| Likely to Apply What Learned | 3.85 |
| Overall | 3.79 |

Ratings ranged from "1" Poor to "4" Excellent

Compassion Fatigue/Vicarious Trauma Training - Evaluation

- Like the use of different media (video, audio, yoga)
 - Liked interacting with others/discussion
 - Upbeat and interactive
 - Presenters were enthusiastic and knowledgeable
 - Great job!
 - Didn't like: No lunch, too rushed, no breaks
-

Compassion Fatigue/Vicarious Trauma Training - Evaluation

How will use the information

- Pay more attention to self care
 - Be more mindful of my actions
 - Put oxygen mask on myself before helping others
 - Train my co-workers
 - Share great handouts with others
 - Not slime anyone
-

Trauma Across the Lifespan

| | |
|----------------------------------|-------------|
| Pre-Arrival | 4.47 |
| Arrival | 4.66 |
| Location/Facility | 4.29 |
| Sharon Wise | 4.80 |
| Bruce Perry | 4.72 |
| Nathan Ross | 4.80 |
| Panel Presentation | 4.65 |
| Friday Afternoon Speakers | 4.07 |
| Overall Conference | 4.56 |

Ratings ranged from "1" strongly disagree to "5" strongly agree

Trauma Across the Lifespan – Most Meaningful

- Sharon Wise, Bruce Perry, Nathan Ross
- Personal Stories
- Research
- Panel Discussion
- Whole Conference

Trauma Across the Lifespan – Suggestions for Improvement

- More time for main speakers
 - More time for questions/panel/discussion
 - Copies of Power Points
 - Policy Makers/Now What?
 - Parking Costs/Break Lines/Lunch/Water
 - Tables/Cramped/Seating/Sound/Bathroom
 - None “Fantastic Conference!”
-

Trauma Literature Review

- Peer Support Specialists have high incidence of past personal trauma
 - Peer Support Specialists, like other helping professions, have high risk of experiencing vicarious trauma and compassion fatigue
 - Trauma is associated with substance abuse, poor health outcomes, job burnout, lower trust and self esteem
-

Trauma Literature Review

- Trauma Treatment
 - Psychological Debriefing
 - Cognitive Behavioral Therapy
 - Psychopharmacology
 - Eye Movement Desensitization and Reprocessing
 - Psychosocial Rehabilitation
 - Creative Therapies
-

Trauma Literature Review

- Trauma-Informed Care
 - Understand early warning signs
 - Reduce other stressors
 - Professional supervision and consultation
 - Professional training on trauma
 - Skill development in caregiving, professional boundaries, conflict resolution, resiliency skills
 - Objective and regular assessment
-

Trauma Literature Review

- Self Care
 - Work system support
 - Adequate time off
 - Relaxation techniques
 - Healthy lifestyle changes
 - Social time
 - Balanced life
 - Spirituality/mindfulness
 - Reducing personal stress
-

TTI Survey/Focus Group Results

| | Adult Consumer | Family Consumer | Adult Peer Specialist | Family Peer Specialist |
|------------------------------------|----------------|-----------------|-----------------------|------------------------|
| Number of Valid Surveys | 70 | 34 | 16 | 26 |
| Number of Focus Group Participants | 57 | 34 | 25 | 31 |

TTI Survey Results

| Type of Trauma | Adult Consumer | Family Consumer | Adult Peer Specialist | Family Peer Specialist |
|--------------------|----------------|-----------------|-----------------------|------------------------|
| Trauma | 81.1% (30) | 70.6% (24) | 93.8% (15) | 96.2% (25) |
| Vicarious Trauma | 45.7% (16) | 47.1% (16) | 87.5% (14) | 76.0% (19) |
| Compassion Fatigue | 54.1% (20) | 57.6% (19) | 75.0% (12) | 80.8% (21) |
| Any Trauma | 84.2% (32) | 85.3% (29) | 100% (16) | 100% (26) |

Percent of respondents indicating they experienced trauma

Trauma Scales

| Trauma Scale | Adult Consumer (N=32) | Family Consumer (N=29) | Adult Specialist (N=16) | Family Specialist (N=26) | All Groups Combined |
|---|--------------------------|---------------------------|----------------------------|-----------------------------|---------------------|
| POST TRAUMATIC GROWTH TOTAL SCORE Range=0-105 | 66.97 (22.90) | 68.39 (25.12) | 79.07 (21.26) | 77.16 (14.97) | 71.83 (21.89) |
| PTSD Symptom Checklist TOTAL SCORE Range = 17 - 85 | 58.04 (15.74) | 45.77 (19.01) | 38.23 (10.41) | 35.38 (14.64) | 45.23 (18.05) |
| I have increased my use of alcohol or drugs. | 1.17 (1.30) | 1.07 (0.37) | 1.07 (0.26) | 1.12 (0.43) | 1.28 (0.23) |

Mean scores and (standard deviations) - Higher scores indicate more growth and more symptoms

Focus Group Results - Trauma

- Trauma training – peer support specific
- Vicarious trauma/compassion fatigue
- Self care
- Employers need to understand trauma
- How not to trigger trauma
- Training on trauma screening tools
- Trauma training for providers/systems

Satisfaction Scales

| Satisfaction Dimension | Average (1-5) (Standard Deviation) | Scoring all "5"s | Percent greater than "3" |
|---------------------------|---------------------------------------|------------------|--------------------------|
| Access | 4.22 (0.81) | 25.9% | 93.2% |
| Quality & Appropriateness | 4.19 (0.74) | 23.3% | 92.3% |
| Outcomes | 3.78 (0.77) | 8.9% | 87.9% |
| Participation in Services | 4.03 (1.05) | 34.4% | 81.1% |
| General Satisfaction | 4.41 (0.75) | 43.5% | 93.4% |
| Ability to Cope | 3.93 (0.83) | 15.4% | 89.0% |
| Social Connectedness | 3.39 (0.90) | 19.8% | 83.5% |

Current Peer Support Services

| | Adult Peer Specialist | Family Peer Specialist |
|--|-----------------------|------------------------|
| What proportion of your work time do you currently spend providing peer support services? | | |
| 0-25% | 14.3% (2) | 8.3% (2) |
| 26-50% | 35.7% (5) | 12.5% (3) |
| 51-75% | 7.1% (1) | 25.0% (6) |
| 76-99% | 28.6% (4) | 37.5% (9) |
| 100% | 14.3% (2) | 16.7% (4) |

Percent by respondent category

Current Peer Support Services

| | Adult Peer Specialist | Family Peer Specialist |
|---|-----------------------|------------------------|
| What proportion of your time is spent working with individuals with mental health and/or substance abuse issues? | | |
| Mostly mental health | 40.0% (6) | 36.4% (8) |
| Mostly substance abuse | 0% (0) | 0% (0) |
| Mostly co-occurring mental health and substance abuse | 26.7% (4) | 40.9% (9) |
| Equally divided among mental health, substance abuse and co-occurring disorders | 33.3% (5) | 22.7% (5) |

Percent by respondent category

Current Peer Support Services

| | Adult Peer Specialist | Family Peer Specialist |
|--|-----------------------|------------------------|
| How many years have you provided peer support services? | | |
| 0-5 years | 66.7% (10) | 66.7% (16) |
| 5-10 years | 26.7% (4) | 20.8% (5) |
| 10-15 years | 0% (0) | 8.3% (2) |
| Over 15 years | 6.7% (1) | 4.2% (1) |

Percent by respondent category

Current Peer Support Services

| | Adult Peer Specialist | Family Peer Specialist |
|--|-----------------------|------------------------|
| How would you characterize the agency you work for? | | |
| Consumer Organization | 26.7% (4) | 4.2% (1) |
| Family Organization | 0% (0) | 87.5% (21) |
| Provider Organization/Other | 73.3% (11) | 8.4% (2) |

Percent by respondent category

Focus Group Results

- Peer support specialists feel supported – state, region, agencies
 - 24 hour peer warm line/drop in centers
 - Program evaluation
 - Facilitator Circle – longer/larger
 - Expand/more resources
 - Access (e.g., transportation)
-

Focus Group Results

- Need for greater communication
 - State/regional trainings
 - Social media
 - Web page forum
 - Networking about resources/lessons learned
 - Marketing
 - Providers
 - System partners/Funders
 - Consumers/Public
-

Adult Peer Support Training Needs

| Competency Areas (Rating from 1 - not valuable to 4 - very valuable) | Adult Peer Specialist Means |
|--|-----------------------------|
| Commitment to recovery, growth, evolution, inspiring hope | 3.57 |
| Personal and relational accountability | 3.29 |
| The power of language (e.g., using language free of jargon, judgments, etc.) | 3.21 |
| Direct honest respectful communication | 3.36 |
| Consciousness raising/critical learning | 3.23 |
| Worldview/diversity/holding multiple truths/trauma informed | 3.57 |
| Mutual responsibility: Belief in the power of relationship | 3.64 |
| Shared risk (e.g., ability to negotiate fear, anger, conflict) | 3.64 |
| Moving towards the positive | 3.62 |
| Creating community/social change | 3.62 |
| Code of Ethics | 3.36 |

Family Peer Support Training Needs

| Competency Areas (Mean scores - Rating from 1 - not valuable to 4 - very valuable) | Family Peer Specialist |
|--|------------------------|
| Effective use of lived experience | 3.33 |
| Listening skills and cultural competence | 3.25 |
| Confidentiality and ethics | 2.83 |
| Effective assertive written and verbal communication | 3.00 |
| Mentoring leadership in others | 3.29 |
| Cultural diversity and use of family-driven/youth-guided resiliency/recovery oriented approach to emotional health | 3.42 |
| Current issues in child developmental, emotional, behavioral, or mental health | 3.42 |
| Parenting for resiliency and wellness | 3.46 |
| Coaching for personal change and crisis prevention | 3.50 |

Focus Group Results - Training

- Suicide/self harm
 - Recovery
 - Communication with other professionals
 - Consumer/Family Engagement
 - Self Care/Trauma
 - Listening/Motivational Interviewing
 - Medication management
-

Focus Group Results - Training

- Working with schools
 - Chemical dependency
 - Coaching skills
 - Rural models
 - Cultural needs of special populations
 - Conflict resolution
 - Court systems
 - Family dynamics
 - Sharing lived experience/boundaries
-

Nebraska Certification Study

Clarification of Terms:

- Current Certification Process
 - Certification Process Through Formal Regulations Process
 - Licensure
 - Accreditation
-

Nebraska Certification Study

Methods:

- Literature Review
- Review of Certification Technical/ Legal Standards
- Survey
- Focus Groups

Recommendations

Nebraska Certification Study

Current OCA Certification Process:

- TTI Development of Training Curriculum and Two Rounds of Train the Trainer
- Any Person with Behavioral Health Lived Experience and 40 Hours Training is Eligible
- 34-Item Written Test (74% pass rate)
- Interview with Three Reviewers
- Continuing Certification Recommendations:
Continuing Education and Co-Supervision
- No Certification Process for Family Peer Support

Family Peer Support Certification

| Certification Organization (Mean scores Rating from 1 - not valuable to 4 – very valuable) | Family Peer Specialist |
|---|-------------------------------|
| Nebraska certification for family peer support | 3.36 |
| National certification for family peer support | 3.27 |
| Certification from a private agency for family peer support | 3.32 |

Adult Peer Support Certification

| Perceived Value of Certification Areas (Mean scores Rating from 1 - not valuable to 4 - very valuable) | Adult Peer Specialist |
|--|--------------------------------------|
| State/region sponsored initial Nebraska Intentional Peer Support Training | 3.54 |
| The written quiz administered after the training | 3.00 |
| The oral quiz administered after the training | 2.54 |
| State/regional continuing education opportunities (e.g., state conference, webinars) | 3.54 |
| State sponsored quarterly co-supervision sessions | 2.09 |

Focus Group: Family Peer Support Certification

- Certification promotes quality of service, provides structure for training, and legitimizes the service
- Needs to be tailored to unique aspects of Nebraska family support

Focus Group: Adult Peer Support Certification

- Nebraska has made great progress
 - NE IPS is good
 - Testing is hard but fair
-

Focus Group: Adult Peer Support Certification

- WRAP as prerequisite to IPS
 - Background checks
 - Three IPS trainers
 - Break up IPS training
 - Test immediately after training
 - Humanize oral exam
-

Focus Group: Adult Peer Support Certification

- Track CEUs
 - Recorded trainings/links to online training
 - Pre-determine CEU credits
 - Minimum CEU requirements/topics
 - Co-supervision – in-person/interactive
 - More networking/training
-

Peer Support Certification Recommendations

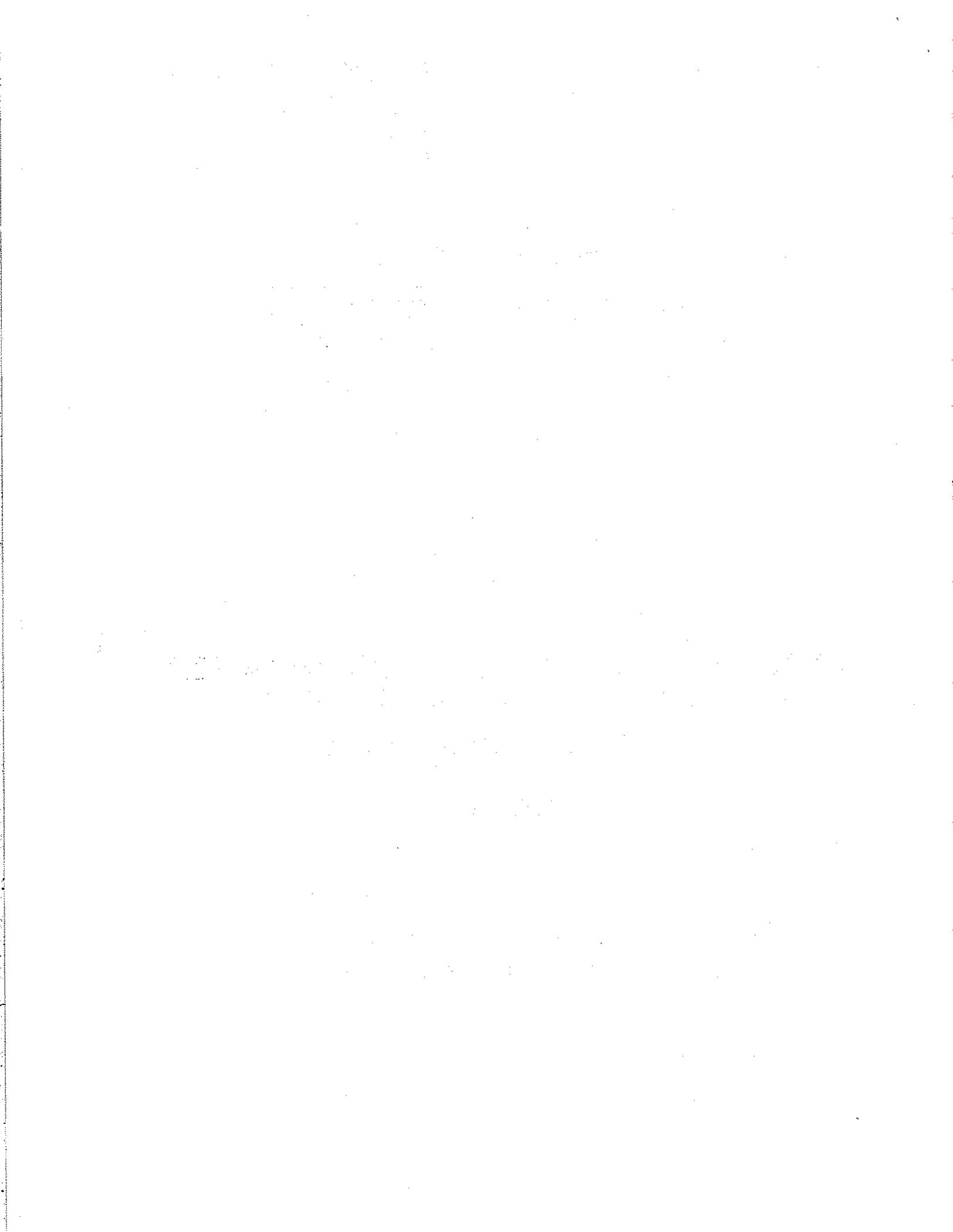
- Continue working on family peer support certification
 - WRAP as a prerequisite to Nebraska Peer Support Training
 - Increase access to Nebraska Peer Support Training
 - Formal appeals and complaint process
-

Peer Support Certification Recommendations

- Establish recertification process
 - Certification revocation process
 - Co-supervision and supervision processes
 - Evaluation and Continuous Quality Improvement
-

Peer Support Certification Recommendations

- Certification through formal regulatory process
 - Separation of certification from training
 - Consider how competencies fit with broader behavioral health competencies
 - Consider national/other state certification & program accreditation
 - Consider financial sustainability
-





Σ

NEBRASKA PEER SUPPORT CERTIFICATION STUDY

JANUARY 2014

The Public Policy Center
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Lincoln, NE 68588 – 0228
Phone: 402 – 472 – 5678
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SECTION 1: STUDY OVERVIEW AND METHODS

To improve the lives of people with behavioral health challenges, Nebraska has invested resources in developing and providing peer support services (services provided by “persons with lived experience with a behavioral health condition” to support other consumers). These services include both adult peer support and family peer support. The state is justified in funding these services since peer support services have been demonstrated to be effective in improving the lives of persons with mental health and substance abuse challenges. To ensure peer support services are high quality, the Nebraska Department of Health and Human Services, Division of Behavioral Health, Office of Consumer Affairs has developed a standard curriculum and certification process for adult peer support services. Curricula are being developed for family peer support services, core competencies have been identified, and discussions are occurring about a certification process for family peer support.

This study is designed to examine Nebraska’s current certification process for peer support services and to identify strengths and areas for improvement. The questions we hope to answer through this study include the following:

1. Nebraska desires to have a valid and reliable peer support certification process. What is the role of the state in establishing standards for competency, training, and certification?
2. What are the standards for effective certification processes and to what extent does Nebraska meet those standards?
3. How well does the process support all components of behavioral health (adult mental health, adult substance abuse, family peer support)? Does peer support apply differently to each area?
4. How does Nebraska’s peer support certification process fit with emerging national efforts to standardize peer support competencies, training, and certification (e.g. National Federation of Families)?

We employed four primary methods for this study: 1) a review of the literature on peer support with a focus on certification processes and an analysis of Nebraska’s current certification process in relation to this literature, 2) a review of legal and technical standards for certification processes and an analysis of Nebraska’s current certification process in relation to these standards, 3) a survey of peer support specialists regarding their perspectives on peer support certification, and 4) focus groups conducted in each region with adult and family peer support specialists.

SECTION 2: OVERVIEW OF NEBRASKA'S CERTIFICATION PROCESS

To orient the reader to Nebraska's Peer Support and Wellness Specialist Training and Certification Process, it may be useful to define and distinguish among four different terms:

1. Current Certification Process. Nebraska currently has a certification process for adult behavioral health peer support specialists. The details of this process are discussed below. "Certification" indicates an individual has met certain requirements such as attending training, passing a written examination, and meeting other requirements of the certification process. Once the individual meets certification requirements, that person may claim to be a certified peer support specialist; however, unlike "licensure" discussed below, certification is not intended to restrict practice to individuals who meet these requirements. Individuals who are not certified may still provide peer support services; however, they may not claim to be "certified" peer support specialists. Nebraska's current peer support certification process has not gone through the formal State rules and regulations process. Because Nebraska's current certification process has no legal basis in regulation or statute, there is no authority to restrict the credential of "peer support and wellness specialist" to individuals who have met the requirements for certification.
2. Formal Certification Process. Formal certification refers to a certification process that is implemented through Nebraska's rules and regulations procedures, and thereby has the force of law behind it. Formal certification would allow title protection for peer support and wellness specialists by allowing the imposition of sanctions on uncertified individuals claiming certification, providing a legal basis for background checks, and including provisions for revocation of certification. Promulgating regulations in Nebraska is a four step process:
 - a. Regulation Drafting – State agencies develop draft rules and regulations and often include stakeholders in this process. This is a period of public input and free exchange of ideas about how the certification process should work and what stakeholders will support.
 - b. Public Notice – Once the draft certification process is ready, the draft regulations must be made available for the public to review. The state agency must provide notice of the public hearing at least 30 days in advance.
 - c. Public Hearing – The hearing provides an opportunity for citizens and stakeholders to comment on the draft regulations. Comments may be taken at the hearing and online. All comments are documented and available for review.

- d. **Submission for Review and Adoption** – After the public hearing, the draft regulations are submitted to the State Attorney General to review for compliance with Nebraska law, then to the Governor for policy review and approval, then to the Secretary of State for final adoption and publication.
3. **Licensure.** Licensure indicates a process adopted through statutory or formal rules and regulations procedures that restricts the practice of a profession to only those individuals who have met the licensure requirements. For example, if Nebraska had a peer support licensure process, an unlicensed person could be subject to legal sanctions for providing peer support services. Most states rely on certification processes to regulate peer support specialist; however, at least one state has considered peer support licensure (Montana Legislature, 2012). In Nebraska, physicians and clinical psychologists are examples of professions that have licensure requirements.
4. **Accreditation.** Certification and licensure refer to processes to regulate individual professional such as peer support specialists. Accreditation, on the other hand, is designed to provide standards and assess organizations and programs such as those delivering peer support services. For example, the Council on Accreditation of Peer Recovery Support Services (CAPRSS) LLC, has established an accreditation process for peer support services (CAPRSS, 2013).

In this section, we describe Nebraska’s current Peer Support and Wellness Specialist Training and Certification Process (often, throughout this report, we use “certification process” to refer to the current Nebraska approach). Through a Transformation Transfer Initiative (TTI) grant from the National Association of State Mental Health Program Directors, the Nebraska Department of Health and Human Services, Division of Behavioral Health (DHHS) developed core competencies for peer support and wellness specialists. Through this same grant, DHHS developed a training curriculum based on the core competencies, code of ethics and the Intentional Peer Support approach. This process involved an extensive involvement of stakeholders. The Behavioral Health Division contracted with the University of Nebraska Public Policy Center (PPC) to administer a competitive bid process to select a highly qualified organization to develop and provide the peer support training across Nebraska as well as training trainers to provide Peer Support Training. The PPC in consultation with the Division, created a Peer Support Steering Committee to develop a Request for Proposals (RFP) and to participate in the review process. This Steering Committee consisted primarily of consumers of behavioral health services. The Steering Committee began meeting on July 27, 2009 and developed the Request for Proposals that was issued September 15, 2009. Proposals were received and reviewed and Focus on Recovery – United was selected to develop the curriculum and conduct the training for Nebraska. The curriculum is available to use in Nebraska and the initial “train the trainers” session was conducted in 2010.

DHHS sponsored train the trainer sessions to sustain the training initiative and in August 2013 conducted a new round of train the trainers for ten additional trainers. The state currently provides peer support training using these trainers and the curriculum. The training is 40 hours and is conducted in-person rather than on-line or self-study and is held twice per year.

Certification of adult peer support specialists is administered by the DHHS Office of Consumer Affairs. Individuals who have behavioral health challenges and who have completed 40 hours of any peer support training are eligible for certification. DHHS administers a 34-item written test that assesses knowledge about the core competencies, ethics and other aspects of peer support based on the training curriculum and code of ethics. The test takes approximately 30 minutes to complete. Individuals must meet a certain standard on the test to be certified as a peer support specialist. The exam has about a 74% pass rate. Individuals seeking certification as peer support specialists must also participate in an interview with three reviewers and answer seven oral questions. Based on the interview, reviewers can approve or disapprove peer support certification.

To keep certification active, peer specialists are expected to maintain a minimum of six hours of continuing education per year and to participate in quarterly two-hour call-in co-supervision sessions. Co-supervision focuses on what is and what is not working well related to the four tasks of Intentional Peer Support. When an individual submits continuing education hours and participates in co-supervision calls, these hours are recorded and maintained in a DHHS data base. If an individual does not keep up their certification requirements, they are expected to take the test again and be re-certified. However, since there was not a defined process for revoking certification, co-supervision and continuing education are no longer required for continued certification. In addition, there is no formal or standard process for de-certification in instances of ethics violations.

A standard training evaluation is administered after each training session. The questionnaire is a paper and pencil survey that asks trainees to rate aspects of the training such as objectives, materials, trainers, etc. There is no pre-post evaluation. DHHS has done a telephone survey of peer support and wellness specialists; however, this was a one-time evaluation. There is no ongoing required evaluation of certified peer support specialist competencies.

Through the leadership of the Nebraska Federation of Families for Children's Behavioral Health, its local affiliates, and the Office of Consumer Affairs, there has been substantial progress in developing core competencies for family peer support specialists. These core competencies may form the basis for developing a family peer support certification process in Nebraska. The competencies are as follows (it should be noted that these competencies are still in development and may evolve over time):

1. Effective use of lived experience
2. Listening skills and cultural competence
3. Confidentiality and ethics (including the Code of Ethics)
4. Effective and assertive written and verbal communication
5. Mentoring leadership in others
6. Cultural diversity and the use of family-driven and youth-guided resiliency-/recovery-oriented approach to emotional health
7. Current issues in children's developmental, emotional, behavioral (including substance use) or mental health
8. Parenting for resiliency and wellness
9. Coaching for personal change and crises prevention
10. Development and use of community resources, including natural support
11. Advocacy across and within systems (education, health, public benefits, behavioral health, etc.)
12. Data collection, evaluation & achieving outcomes
13. Networking

SECTION 3: LITERATURE REVIEW

1. Origin and development of peer support services

The first President Commission on Mental Health (1978) and The New Freedom Commission Report (2003) favored the transformation of traditional mental health services into client-centered community-based mental health services focusing on clients' recovery. This transformation proposed an evolution from passive to proactive clients advocating for their own recovery. In this sense, peer support services have had a key role in both enhancing the connection between the community and mental health costumers and empowering costumers so they could become advocates of their own recovery.

Three important trends have facilitated the integration of peer support within current behavioral health delivery systems; first, is the increasing research base demonstrating the efficacy and cost effectiveness of peer support services (Repper & Carter, 2011); second, based on the recognition of peer support services as effective interventions, the trend to finance these services through traditional financing mechanisms such as Medicaid and Federal Mental Health Block Grant funding (Sabin & Daniels, 2003); and third, the development of peer support services gave rise to suggestions for ensuring and enhancing the quality of services through mechanisms such as certification of peer support specialists (Daniels et al., 2010).

2. Definition and types of peer support services

Peer support services are currently defined as those services in which consumers, who are successful in their recovery and have experience in navigating the behavioral health system, are employed or volunteer in the mental health system to offer guidance and assistance to current consumers (Mead, Hilton, & Curtis, 2001). While this specific role of successful peers as models for current clients has been recently developed, other roles of peer providing advice and assistance have a long tradition.

Davison, Chinman, Kloos, Weingarten, Stayner, and Tebes (1999) identified three different types of peer support. The first two originated as an alternative of traditional mental health system and have a long tradition. These types are *Natural mutual support* and *Consumer-run organizations*. The third type considers *peer specialists as mental health providers* and has received major attention from empirical and practical perspectives. This is the most recognized type of peer support and when policy makers refer to peer support in general, they usually refer to this specific type.

Natural mutual support is the least sophisticated form of peer support in which two persons share common experiences that help to understand their situation (Davison, Chinman, Kloos, University of Nebraska Public Policy Center

Weingarten, Stayner, & Tebes, 1999). The recovery process in this type of peer support is based exclusively on mutuality between the provider and the costumer (Repper & Carter, 2011). An example of this service is the GROW organization (Gracia et al, 2005). This type of intervention has led to positive outcomes in inpatient populations with severe mental illness (Bouchard & Gross, 2010). Goldstrom et al. (2006) estimated that there are 3,315 groups in the U.S. under the category of mutual support groups with an approximate attendance of 41,363 persons per meeting.

Consumer-run organizations are the second type of peer support. In this type, consumers run structured programs that do not operate under the conventions of therapeutic work. There is currently a trend in which these programs cooperate with state mental health agencies (Davison et al., 1999; Repper & Carter, 2011). Current literature supports the effectiveness of these types of programs in clients' recovery (Segal, Silverman, & Temkin, 2011; Tanenbaum, 2012a; Tanenbaum, 2012; Yates et al., 2011). Goldstrom et al. (2006) estimated that there are 1133 groups in the U.S. under the category of consumer-operated services serving a total of 534,551 clients a year.

Peer specialist as a mental health provider is the most widespread role in peer support services. Contrary to the other two types, the peer specialist is a part of the staff in a mental health agency. Therefore, peers specialists receive formal training and are supervised by another mental professional (Solomon, 2004). To date, approximately 30 states have certified peer support workers and 16 of these states are obtaining Medicaid reimbursement for this service (Daniels et al., 2010; Grant, Reinhart, Wituk, & Meissen, 2012).

3. Peer support specialists as mental health providers

A. Efficacy and effectiveness of peer specialists as mental health providers

Efficacy and effectiveness of peer providers' interventions has been supported by randomized and non-randomized control trials with different populations, in different settings, different forms of intervention, and with different treatment delivery options.

Population and settings

Peer support has led to positive outcomes with clients with *severe mental illness* in *randomized* (Cook et al., 2012; Davinson, Chinman, Sells, & Rowe, 2006; Sells, Davinson, Jewell, Falzer, & Rowe, 2006; Sledge, Lawless, Sells, Wieland, O'Connell, & Davinson, 2011) and *non-randomized* (Demartis, Galanter, Trujillo, Rahman-Dujarric, Ramaglia, & LaGressa, 2006) control trials with both *inpatient* (Demartis, Galanter, Trujillo, Rahman-Dujarric, Ramaglia, &

LaGressa, 2006; Sledge, Lawless, Sells, Wieland, O'Connell, & Davinson, 2011) and *outpatient* (Cook et al., 2012; Sells, Davinson, Jewell, Falzer, & Rowe, 2006) populations. Similarly, peer support has become a crucial tool in the prevention (Cuijpers, 2002) and treatment (Blondell et al., 2011) of *substance abuse*, reducing the impact of *catastrophes/trauma survivors* (Hardiman & Jaffee, 2008; Renner, Bänninger-Huber, & Peltzer, 2011), coping with *bereavement* (Aho, Tarkka, Astedt-Kurki, Sorvari, & Kaunonen, 2011; Barlow et al., 2010), and other general Medicaid problems such as *housing* (Tsai & Rosenheck, 2012).

Further supporting the efficacy of peer specialist interventions, literature showed that these types of interventions are equally effective compared to the best available treatments in randomized control designs. Thus, in the case of depression (Pfeiffer et al., 2011), and trauma survivors (Renner, Bänninger-Huber, & Peltzer, 2011) the effect of peer support interventions was equal to empirically based treatments and superior to usual care or minimal attention conditions in reducing clients' symptomatology.

Forms of intervention

Literature indicates that there are some major training programs that are considered specific peer-led interventions which have showed to be efficient in helping psychiatric clients recover in randomized control trials. These specific interventions are currently part of the certification and training program of peer specialists. Among them, the most relevant are the *Wellness Recovery Action Planning* (WRAP) (Cook et al., 2012), *Health and Recovery Peer* (HARP) (See Cook, 2011), *Building Recovery of Individual Dreams and Goals* (BRIDGES) (Pickett et al., 2012) and other specific interventions within the NAMI Training Programs (Burtland & Nemecek, 2007).

Different forms of treatment delivery

With respect to service delivery, while the majority of the studies highlight client-peer specialist interactions occurring in group sessions or individual meetings, current studies are expanding on these forms of treatment delivery to incorporate other forms such as online chats (Fukkink, 2011) or phone calls (Dalgin, Maline, & Driscoll, 2011).

B. Peer support specialist benefits and challenges when promoting clients' recovery

Repper and Carter (2011) reviewed seven randomized control trials in order to uncover the impact of the employment of peer support specialists as mental health providers. These authors noted that benefits for consumers of peer support services were varied in nature but could be summarized in major areas. First, engaging in positive relationships with peer specialist exposes consumers to different role models that increase their understanding of their own illness. Second, gaining understanding increases self-acceptance and reduced the negative impact of social

stigma. Third, with self-acceptance comes hope in a better future. Fourth, the increase in hope results in costumers becoming active agents of their own recovery. Fifth, by facilitating adaptation, costumers feel empowered and able to find their own solutions in the community services. Sixth, increases in problem-solving skills translate into decreases in the hospital admissions rates and increases in the sense of belonging to the community.

In addition to the positive outcomes for mental health costumers, current literature indicates that providing peer support is not only beneficial for those who receive the service (Repper & Carter, 2011; Moran, Russinova, Gidugu, Yim, & Sprague, 2012) but also for those delivering the service (Bracke, Christiaens, & Verhaeghe, 2008).

While benefits of peer support interventions are sound, the development of the peer support profession has experienced challenges. Repper and Carter (2011) identified four issues: 1) the impact of boundary crossing in peer-costumer relationships because peers specialists are usually perceived as “friends” and not mental health professionals, 2) formalizing peer support may move the peer support relationship away from the original goal of mutuality of pccr relationships, which increases power imbalance, 3) the possibility that peer specialists might experience stress by their occupation (including vicarious trauma and compassion fatigue) and experience relapse in their own recovery, and 4) issues around how peer specialists might be held accountable for interventions.

C. State mental health administration: Certification of peer specialists and Medicaid reimbursement

To date, there is wide variability of certification programs that states can follow. Similarly, there are alternatives to incorporate peer support services under Medicaid programs. How each program is certified and incorporated under Medicaid programs is highly dependent on each state’s needs. However, in some instances most states follow the Georgia and Arizona models because they were the first states incorporating peer support to their Medicaid programs in 2001.

Certification process

Requirements for peer specialists

Johnson (2008) found that the common requirements for peer support specialists were:

1. Have reached certain age (i.e., 18 or 21 years old)
2. Certain education level, which usually was GED
3. Have a primary diagnosis of mental illness
4. Be a current or former customer of mental health services

5. Demonstrate leadership and advocacy skills
6. Have a strong dedication to recovery
7. Some states incorporate the requirement to have work experience

Training process

Johnson (2008) analyzed the different options that states can adopt in order to meet the requirement of formal training of peer support specialist if Medicaid reimbursement for this service was one of their goals. These programs could either be module-based training or require a minimum number of hours (Daniels et al., 2010). These options are:

1. **States could develop their own training curriculum.** This option is the case of Washington and Maine.
2. **States could adapt the Georgia 40-hour training program.** This option was the case of Hawaii, Michigan, South Carolina, Washington DC, and Iowa for example.
3. Pennsylvania and North Carolina have adopted **the Recovery Opportunity Center (META).**
4. Approximately 17 of the remaining states have adopted **the ROC Peer Employment Training (80-hour course).**

The state of Nebraska adopted the Transformation Transfer Initiative from SAMHSA or TTI Grant in 2009. This grant allowed the state to purchase training from Focus on Recovery United, which included Heather McDonald of FOR-U, Chyrell Bellamy of Yale University, and Shery Mead and Chris Hansen of Shery Mead Consulting. A curriculum for the State of Nebraska's Office of Consumer Affairs was purchased that focuses on trauma-informed Intentional Peer Support. The state of Nebraska offers one or two trainings a year.

Certification exams

According to Johnson (2008), only Pennsylvania and North Carolina do not require a certification exam. The rest of the states have their own certification exams (e.g., Washington, Georgia, Illinois, Missouri, and Hawaii) or if they have adopted the ROC Peer Employment Training, there was a specific test designed for its content.

In the state of Nebraska, all persons that take the 40 hours of any Peer Support training are invited to sit for a statewide exam to become Certified Peer Support and Wellness Specialists. To

keep one's certification in Active Status, the State recommends a person maintain quarterly co-supervision and six hours of continuing education annually.

Ethical sanctions

Similar to other mental health professionals, peer support specialists are bound to specific codes of conduct that provide a standard of practice that they might follow. While each state has its own ethical code, they usually include the following major elements:

1. Maintain high standards of personal conduct
2. Ensure that all their interventions are destined to promote costumers' recovery
3. Do not participate in any form of discrimination
4. Peer support specialists respect privacy and confidentiality
5. Never engage in sexual/intimate activities with consumers they serve
6. Shall not accept gifts of significant value from those they serve
7. Will not abuse substances under any circumstance
8. Acknowledge the limits of their expertise
9. Will not use relationships with people they serve to financial gain or to put that person at risk of exploitation

At present, states like Texas that are currently developing the policy and procedure manuals for peer support certification (Via Hope Texas Mental Health Resource, 2011), are incorporating not only codes of conduct, but also rules of conduct, complaints procedures, and sanctions that might be imposed if a certified peer specialist violates any professional rule.

Medicaid reimbursement

Center for Medicaid and State Operations: General requirements

On August 15, 2007, the Center for Medicaid and State Operations (CMS) offered guidance for states interested in covering peer support providers to Medicaid eligible adults with mental illnesses and/or substance use disorders. While CMS allows each state to develop its own mental health and substance use delivery system, the state Medicaid agency continues to have the authority to determine the specific service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service. In the case of peer support specialists, the policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers that have to be defined by the state. Therefore, in order to be considered for federal reimbursement states must identify the Medicaid authority and describe the service, the provider of the service, and their qualifications.

Three approaches for Medicaid reimbursement

Johnson (2008), as part of a consultant's report assessing the Minnesota Peer Support Implementation, identified three different approaches in which states incorporated their peer support services under the Medicaid programs:

1. Included as a discrete service - The states of Arizona, Georgia, Pennsylvania, and Washington are examples of this approach.

2. As part of another Medicaid reimbursed service - The states of Georgia, Hawaii, North Carolina, Maine Illinois, Wisconsin, South Carolina, Michigan, and Oregon are examples of this approach.

3. Provided through a licensed or credentialed "Peer Support organization"- The states of Arizona, Georgia and New Hampshire are examples of this approach. Nationally, peer-run organizations have expanded greatly and have increased the types of activities they engage in, including peer support services (Lived Experience Research Network, 2013).

4. Conclusions

The need to transform the traditional mental health system in the U.S. into client-centered community-based services stresses the need to promote the role of peer support specialists. Peer support specialists empower clients to advocate for their own recovery and at the same time re-connected them with the community.

At present, peer support specialists are treated similar to other mental health providers within the mental health system. For this reason, research has been conducted to demonstrate empirical efficacy and effectiveness of peer support interventions and major efforts have been made to ensure peer support specialists have the skills needed to provide high-quality peer support services such as developing standard training curricula and establishing certification processes.

Thus, peer support is an evidence-based practice that is continuously testing its efficacy and cost-effectiveness with different populations, settings, and forms of intervention. In this sense, the different forms of interventions follow the same form of efficacy checking as psychological empirically supported treatments. This means that most of the efficacy of peer support interventions is tested using specific experimental designs (i.e., randomized control trials) by different researchers in different settings.

Similarly, peer support certification processes have emerged in many states, which includes providing peer support specialists with formal training and meeting requirements of competency-based evaluations. After obtaining certification, these specialists often are required to accomplish a certain amount of hours of continuing education.

The major consequence of the integration of peer support specialists in the mental health agencies is that these services are eligible for Medicaid reimbursement. While each state has their own requirements and accreditation process to certify peer specialist, there are common requirements they must follow. These requirements include 1) professional supervision in the setting of practice, 2) care-coordination that integrates the intervention of peer specialist within the costumers' treatment goals, and 3) specific training criteria for peer support providers.

SECTION 4: LEGAL AND PROFESSIONAL STANDARDS

Overview of Legal Liability Concerns and Certification of Peer Specialists

Peer support specialists are specially trained and certified individuals with personal experiences in addiction and recovery. As a result of their experiences and special training, they are able to provide peer support and assistance to consumers in need. As peer support approaches have become increasingly popular in recent years, concerns about liability for training and employment of peer support specialists have arisen. Certification procedures exist for peer support workers to become Certified Peer Specialists (CPS) in many states.

Professional certification is different from licensure. Certification is a public statement that a particular standard of quality or knowledge has been achieved by a professional. Licensure, in contrast, is typically a governmental permission to practice a profession or render a service after a minimum level of competence has been obtained (Institute for Credentialing Excellence).

Certification of peer specialists is considered an indication of quality, and not a license to practice, or an indication that they are professionally associated with or obligated to the certifying state government. Most legal liability concerns are raised in the licensing context because of the importance of licensing to the practice and regulation of professions. Licensing is mandatory in order to practice professionally. Certification is voluntary, and serves as a statement of quality or accomplishment. For these reasons, there is generally less legal scrutiny of the peer specialist certification processes than there would be for licensing processes; however, liability issues that apply in the licensing context should be considered in the certification context as well.

There are five general areas in which liability concerns could arise in regards to CPS: 1) Negligence, 2) Due Process, 3) Anti-trust, 4) Defamation/Label, and 5) Civil Rights/ADA.

Negligence

A negligence concern may exist if there is fear that liability would extend to a certifying body for the acts of a peer specialist. Liability theory traditionally requires that a duty of care is owed to a potential plaintiff by a certifying body, and that a breach of duty occurred (negligently or recklessly) that caused some harm to a plaintiff. In the case of a certifying body, it is presumed that the act of certification must be somehow tied to a resulting harm, which would be a difficult causal connection to make. It is more likely that other forms of vicarious liability for the actions of a peer specialist might exist for a peer specialist's employer. A principal question determining liability is whether the certifying body had control over the actions of a certified peer specialist (Snyder v. American Association of Blood Banks, 1996). Without control, it would be difficult to assert that a certifying body should be liable for the negligent actions or omissions of a peer

support specialist (Salzer & Kundra, 2010). Nevertheless, negligence is a potential cause of action that may arise from a poorly designed certification process.

Due Process

Due process concerns traditionally involve assertions that the government is depriving “life, liberty, or property, without due process of law.” In the licensing context, due process assertions are raised if the licensing body —typically a government entity—revokes a license, or denies a license, without fair procedural or substantive due process, thus depriving someone of being able to practice their profession. The federal courts have examined due process claims and created requirements for administrative hearings by government entities (Goldberg v. Kelly, 1970; Mathews v. Eldridge, 1976). Generally speaking, due process requirements in licensing reviews include providing sufficient notice, opportunities to be heard by the applicant, presentation of evidence, impartial adjudicators, and opportunities for judicial review (Garris v. Governing Board of South Carolina Reinsurance Facility, 1998). It should be noted again that due process concerns have typically been associated with licensing processes, because professional licensing dictates whether an individual can practice their profession. It is less clear how certification processes might be implicated, but as a general recommendation, it is advisable that certification processes be administered with the same standards in mind: consistently applied, transparent, and fair processes and standards.

Anti-trust

Anti-trust concerns in the licensing context are traditionally associated with allegations that licensing denial or revocation unfairly serves as a barrier to competition in commercial activity. For example, if a professional licensing process barred a class of individuals from competition with no reasonable basis for that bar (e.g. gender, race, etc.), an anti-trust claim may exist as to that licensing scheme. Because certification is not a requirement to practice, it is unlikely that certification processes would implicate anti-trust theories, especially if certification processes are transparent and reasonably related to professional competencies. Both certification and licensing processes can impose requirements or restrictions if they are rationally related to legitimate professional objectives, such as educational requirements, standards of conduct, and so on. Unrelated restrictions with no intent other than to restrain competition would be scrutinized under anti-trust theories (Havighurst & King, 1983).

Defamation/Libel

Defamation (verbal) and libel (written) concerns might arise in the certification process. This generally refers to the communication of harmful and false information about a person or entity to a third party. Defamation can occur in a wide variety of contexts not specific to certification or peer support. As a general precaution, conclusions made about a certification applicant should not be shared outside of the certification context. Considerations should be given to adequate training and screening of certification reviewers.

Civil Rights/ADA

Discrimination claims might arise in certification revocation or denial contexts. The principle legal scheme that might be implicated is the Americans with Disabilities Act (ADA). The ADA prohibits discrimination against persons with disabilities in all government activities, thereby including state licensing or certification activities. In ADA claims, a plaintiff can prove discrimination if he or she is perceived to be disabled and is qualified for a job, but is not hired, or is subjected to heightened scrutiny or different dispositions. There are several exceptions to the ADA; an important exception in the mental health area is that a hiring need not occur if there is a legitimate determination that it may result in a threat to the health or safety of others.

Within the licensing context, several ADA lawsuits have been filed asserting discrimination against mentally ill individuals (*Clark v. Virginia Board of Bar Examiners*, 1995; *Ellen v Florida Bd. Bar Examiners*, 1994). The typical concern is that a licensing board may feel compelled to reject an application or revoke a license if a person is deemed a threat to health or safety because of a mental health or medical condition. It is important to note that real risks of threat due to mental health or medical reasons can exist, and several courts have ruled that ADA protections do allow for licensing revocations in those circumstances (*Kirbens v. Wyo. State Bd. of Med.*, 1999; *Colorado St. Bd. Medical Examiners v. Ogin*, 2002). However, actual “threats” to health or safety must exist, rather than just generalized fears based on an individual’s mental or behavioral health condition. A rejection, revocation, or dismissal based on a generalized fear would amount to the type of discrimination that the ADA was intended to prohibit. Likewise, if an individual is unable to adhere to certain essential conduct standards of a job due to a disability, that does not entitle that person to ADA protections (*Starnes*, 1999). Certification processes should be designed to ensure they do not violate ADA requirements.

Overview of Certification Standards

There are a number of national accreditation bodies and institutes that provide guidance for certification processes and standards including the Institute for Credentialing Excellence, the American National Standards Institute – Standards for the Accreditation of Certification Processes and the BSI Standards for Bodies Operating Certifications of Persons. The following is a summary of relevant standards that may provide guidance for Nebraska’s Peer Support Credentialing Process.

Generally, the certifying entity should have a documented objective and reliable certification process. The certification should be based on solely on competency to the skills and knowledge required to perform specified duties and responsibilities. Certification should be based solely on information gained through the certification process and not on extraneous information. The structure of the certification process must have the necessary resources, management

components and information management capacity to ensure quality, validity and reliability. The certification structure should include 1) criteria for initial certification and recertification, 2) assessment methods for initial certification and recertification, 3) surveillance method and criteria to ensure continuing adherence to standards, and 4) criteria for withdrawing certification. The certifying entity should identify and document the associated threats to its impartiality on an ongoing basis; the entity should have a documented process to demonstrate how it eliminates or minimizes those threats.

The certification entity should have documentation to demonstrate a job or practice analysis that is conducted and updated to include the following:

- Identify the tasks for successful performance
- Identify the required competence for each task
- Identify prerequisites necessary for the competencies
- Confirm the assessment mechanisms and examination content
- Identify the recertification requirements and interval required for recertification

The certification entity should ensure the certification scheme is reviewed and validated on an ongoing, systematic basis. The process should be published and readily available to any interested individual.

The certification process should include an agreement that is signed by the certified person covering the following:

- Compliance with certification process requirements such as a code of ethics
- A commitment to discontinue claims to certification if certification is suspended
- A promise to inform the certification body of matters that affect capability of the certified person
- Non-disclosure agreement to not disclose examination materials
- Consent to providing review information related to the certification process

There are a number of guidelines to ensure the certifying entity has sufficient resources dedicated to the certification process. The certification entity should provide its personnel with documented instructions describing their duties and responsibilities and require its personnel to sign a document by which they commit themselves to comply with the rules defined by the certification entity, including those related to confidentiality, impartiality and conflict of interests. The certification entity should monitor the performance of examiners and assess the reliability of examiner judgments. The certification body should have a documented description of the responsibilities and qualifications of other personnel involved in the assessment process. The certification body should have a legally enforceable agreement covering the arrangements including confidentiality and conflict of interest with each body that provides outsourced work related to the certification process.

Special safeguards may be necessary when training and certification are administered within the same legal entity; this combination poses a potential threat to impartiality. Efforts should be made to ensure independence of the two processes. There should be ongoing assessment of threats to impartiality. There should be a separation of trainers and examiners; this may include restrictions such as having a defined period of time from the end of training to the point at which a trainer can act as an examiner for a former trainee. Finally, there should be no impression given that participation in the training from the certification entity will provide an advantage to the applicant.

The certification entity must have the capacity to maintain high quality records and information to support the certification process. This capacity should include maintaining records to confirm the status of a certified person, ensuring confidentiality and integrity of records, having policies for maintenance/release of information, and providing a unique certificate for each certified person. Procedures should be in place to ensure certified individuals inform the certification body about any issues that may impact the person's ability to meet the certification requirements. The certification entity should enact procedures preventing fraudulent exam practices; these procedures may include requiring candidates to sign non-disclosure statements, having adequate supervision of the testing process, and monitoring testing results for evidence of cheating.

The certifying body should maintain an ongoing evaluation system to continuously assess its testing procedures and certification processes. This evaluation system should include 1) monitoring the consistency of testing administration, including conformity with established and written testing procedures, 2) reviewing state of art in performance standards to ensure up-to-date information is included in the testing process, 3) monitoring test result data to protect against disparities based on factors such as race, ethnicity, gender, or socio-economic status, 4) managing audits to ensure all aspects of the certification process meet best certification practice standards, and 5) gathering feedback from applicants and certified persons related to the certification process. The evaluation system should include a process for identifying actions to remedy deficiencies and objective measures to document how and when deficiencies are remedied. Ideally, the evaluation system should have a process to identify and prevent potential nonconformities, document corrective actions and monitor the success of these actions.

The certifying body should have standard procedures in place for appeals related to the certification process including procedures to accept and review appeals, make decisions, and notify appellants about progress and final decisions. Standard procedures for receiving and addressing complaints about the certification process or certified individuals should be developed. The certifying body should have documented procedures for maintaining ongoing certification including any requirements for continuing education and processes to document these requirements. Procedures for recertification including any time frames for re-testing or other ongoing assessment should also be developed. The certification body should have

procedures to suspend or withdrawal certification for individuals no longer meeting certification requirements; these procedures should include requirements that the individual no longer claim certification.

SECTION 5: SURVEY AND FOCUS GROUP RESULTS

The University of Nebraska Public Policy Center conducted a survey and focus groups in each of the behavioral health regions of Nebraska during September and October 2013. Included in both the surveys and focus groups were questions about Nebraska's peer support certification process. The results from the survey and focus groups are discussed separately. It should be kept in mind this report summarizes the responses of participants in the focus groups and surveys; the University of Nebraska has not endorsed the recommendations proposed nor verified the accuracy of statements made.

Survey Results

The survey included two respondent groups: 26 Family Peer Support Specialists and 16 Adult Peer Support Specialists. There is not a separate certification process for family peer support specialists. The 26 Family Peer Support Specialist participants were asked how valuable they believed certification would be based on who administered the certification process: State of Nebraska, National Group, or Private Group. As shown in Table A1, the average respondent thought certification would be quite or very valuable for family peer support specialists. There were no substantial differences regarding the organization that should administer the certification process.

Table A1: Family Peer Support Specialist Perceived Value of Certification by Certifying Organization - Mean (Standard Deviation)

| Certification Organization | Family Peer Specialist |
|---|------------------------|
| a. Nebraska certification for family peer support | 3.36 (0.90) |
| b. National certification for family peer support | 3.27 (0.99) |
| c. Certification from a private agency for family peer support | 3.32 (0.84) |

1= Not valuable

2= A little valuable

3= Quite valuable

4= Very valuable

Fourteen of the 16 Adult Peer Support Specialists answered whether they were certified; 12 of the respondents were certified and two were not. Of the two who were not certified, one indicated he or she had not taken the test yet, and the other indicated lack of training in Nebraska had been a barrier.

Adult Peer Support Specialists were asked their opinions about the value of different areas of the certification process. As shown in Table A2, Adult Peer Support Specialists considered the state/region sponsored Nebraska IPS training and state/regional continuing educational

opportunities to have the greatest value. The state-sponsored quarterly co-supervision sessions were considered “a little valuable.”

Table A2: Adult Peer Support Specialist Perceived Value of Certification Areas - Mean (Standard Deviation)

| Certification Areas | Adult Peer Specialist |
|---|-----------------------|
| 1. State/region sponsored initial Nebraska Intentional Peer Support Training | 3.54 (0.78) |
| 2. The written quiz administered after the training | 3.00 (1.23) |
| 3. The oral quiz administered after the training | 2.54 (1.20) |
| 4. State/regional continuing education opportunities (e.g., state conference, webinars) | 3.54 (0.66) |
| 5. State sponsored quarterly co-supervision sessions | 2.09 (1.22) |

1= Not valuable
 2= A little valuable
 3= Quite valuable
 4= Very valuable

Adult Peer Support Specialists were asked an open ended question regarding what could be done to improve the peer support certification process. The following are the responses:

- 1. Have more facilitator training; 2. Have co-supervision face to face; 3. Have a curriculum of webinars; 4. Provide networking for peer consumers; 5. Have a website with peer resources and peer contact numbers; 6. Make credentials have a higher social value
- Available to anyone who pursues regardless of ability to pay, transportation, resources (i.e. Western Nebraska - way out west)
- Have more trainers. Make it more accessible for those who can't take a week off of work to complete. Have more opportunities to "take the test" closer to when you finish the training
- Have more training so that more people can be certified. Have each certified specialist submit one or two questions for the certification test
- I believe that our state peer support certification process is amazing already. At this time; I cannot think of any improvements
- More frequent trainings
- The board of certification recognizes the credentials like they have in Iowa. I believe a national credential is soon on the horizon also. The more we can do to professionalize the career option for Peer Support the better. I think also it should be made more known as a way to transition out of disability for those skilled enough to provide Peer Support full time

- The entire process needs to be looked at - from the availability of training to the testing of competence, to ensure that peer support remains a legitimate and viable service. In addition, the existing code of ethics needs to be rewritten in a professional manner to better reflect professional work competencies, responsibilities and focus of service (see International Association of Peer Supporters Draft National Practice Standards <http://inaops.org/national-standards/>)
- Train region specific

Focus Group Results

Family peer support specialists were asked what they thought of certification. Many participants supported certification for family peer support specialists and thought it would provide recognition of peer support as a legitimate service. Many thought certification would provide a structure for ongoing education and ensure requirements for skill enhancement. Other comments about family peer support certification include the following:

- It is unclear what the best criteria would be for certification. Having life experience and passion is the most important characteristic of a successful peer support specialist. That is a difficult characteristic to measure or identify because it is so intangible.
- Having a certification process would be helpful because it provides a foundation for training. It also helps to keep skilled professionals in the sector. It is important that there is an incentive to keep good family support specialists working in this area. There needs to be a process to identify and recognize those individuals who are really experienced and passionate in this area.
- If there is a certification process, having both a State of Nebraska certification and a national recognition or certification process would be good. National certification recognizes evidence-based practices that have been tested elsewhere.
- There should be a way for people who have been doing the work for many years to be grandfathered in to certification without having to take any tests. It is unfair to have to test those peer support workers, particularly because many peer support specialists may be in a phase of their life where they are beyond studying and testing.
- Certification can be very important because it assures the family member that you are qualified and have undergone some form of quality assurance. However, the form of the certification process is very important. Any sort of test should be constructed by someone who is familiar with family peer support. A very good component would be to have a member of the certification board observe you in your work so they know you are competent. Thus, you need to have both a classroom test and a “field test” so the reviewers know that candidates know what they are doing, particularly in times of crisis.

- A state certification process is preferable over a national one. It needs to be geared towards Nebraska and Nebraska families. Nebraska is not Louisiana, it is not New York. The needs are too different for there to be a national certification.
- Family peer support advocates need to have a say in developing the testing process for certification. They know what works and what does not. The proper input is needed so the testing reflects the skills and knowledge that are necessary. It is hard to define or limit the roles and responsibilities of family peer support. They do it all. They encounter all sorts of different, completely unpredictable situations. They manage the best and worst of life in all situations. They are life coaches. How can one “test” to all the situations that could be encountered as part of the job?

Adult peer support specialists were asked detailed follow up questions about certification. Many participants indicated their belief that Nebraska has made great progress in recent years in peer support certification and peer support services in general. Most people felt the Nebraska Model Training – Intentional Peer Support (IPS) was good and the written and oral testing processes were appropriate and an integral part of the certification process. Some indicated the testing process was effective in filtering out candidates who are not qualified. Some participants found the testing and oral exam petrifying but thought going through the process ensured they had the requisites to do peer support. A number of participants indicated the training was based on internalizing the training and not memorizing the materials, focusing on how to use the training in one’s own life and as a peer support specialist. They agreed with the philosophy from the Office of Consumer Affairs that the training was not designed to produce “trained parrots.” A number of participants thought the co-supervision calls were valuable because they enable specialists to work through problems they may be experiencing and generate appropriate solutions.

Peer support specialist recommendations for improving the certification process included the following:

- Some participants suggested Wellness Recovery Action Plan (WRAP) training should be a pre-requisite for the Nebraska Model (IPS) training. Individuals are given a book on WRAP, but it is meant to be facilitated training and not just self-taught. There is little funding for WRAP training and what is offered isn’t well attended. Providing funding and mandating would be worthwhile. There should be more recruiting and advertising of WRAP training and facilitators should be paid.
- Some participants recommended clear standards for certification (the standards seem to change and are not widely communicated) and they should be the same for everyone (it appears some requirements are waived for some individuals). Making the standards consistent for all people will ensure legitimacy of the certification process.

- Some participants suggested doing background checks on individuals applying for certification to make sure individuals with criminal backgrounds or sex offenders could not hold themselves out as certified peer support specialists
- Some participants indicated previously there was a requirement that facilitators had to go through IPS training before they went through facilitator training. This requirement is apparently gone, but should be reinstated.
- Some participants thought there should be three facilitators for the Nebraska IPS training. Some trainings apparently had two trainers and two was not enough. Many of the topics bring back painful memories or trauma and trainees need to step out of the training; having three trainers allows one to check on these individuals.
- There were mixed ideas about breaking up the Nebraska IPS training across multiple weeks. Some participants recognized that having it during one week makes it more likely individuals will attend all sessions because they have set aside this time for the training. If a person misses more than four hours of the training, he or she has to retake the training. However, participants also recognized advantages of extending the training over several weeks including 1) allowing more time for homework and opportunities to practice what they learn in class and 2) avoiding burnout by trainees and trainers; some believe that at the end of a full week of training, trainees were not able to retain much information and trainers were tired.
- Some respondents thought that regional level training, particularly in rural areas, is needed since issues faced by peer support specialists are often unique to each region of the State. This would reduce the need to make them travel long distances. There are few funds available to help individuals travel long distances to take the test.
- Many participants indicated they were nervous going through the oral exam. One aspect of the oral exam that made them particularly nervous was the flat effect and lack of eye contact with examiners. Although participants understood the reason for this is to provide an objective testing environment and to avoid giving unintentional clues to test takers, many thought testers could still accomplish this but should at least acknowledge that they hear and understand what the test taker has to say. The oral exam would be a more humanizing experience if testers would make eye contact and give attention to the test taker while they talk, then do their writing after the tester completes his or her response.
- Some participants thought the test should be given right after the training. Conducting the test a month after the training requires additional travel time and time away from work.
- Some individuals thought the quiz and oral exam had tricky wording that tried to catch people, so test takers would try to guess what examiners were looking for instead of concentrating on what was important in peer support. There was not consensus on this point. Many participants thought the test was fair but felt they had climbed Mount Everest when they got through it. Some thought peer support specialists should have input into the test questions and the testing process to make it less intimidating.

- There was also discussion about whether the test focused too much on Intentional Peer Support. Some thought the state had gone through an extensive process to choose the curriculum and it was appropriate to have the testing process focus on this curriculum; from their perspective, the test appropriately reflected the curriculum. Others thought the current test deviated too much from the IPS curriculum and the test questions should come directly from [Shery] Mead to more closely reflect the curriculum. Still others thought the testing should be broader and include materials from other courses.
- Participants had different ideas about requiring continuing education units for ongoing certification. Most thought Continuing Education Units (CEUs) should be required, but some participants thought the requirements were hard to meet and took time away from their work or their families. There were a number of suggestions about improving the CEU process:
 - Some participants thought there should be requirements for CEUs and they should be tracked by individual at the state level; tracking CEUs honors the people doing peer support and recognizes their efforts participating in training. Other participants thought CEUs could be tracked at the regional level.
 - Some participants would like a library with recorded trainings or web site with links to training, including SAMHSA training and other national webinars, so they could complete training on their own time and have resources for learning key topic areas. Webinars that individuals could access at their convenience would be ideal. Others however, thought that webinars were hard to access technologically for some people and the human connection is lacking. For in-person training, the trainings should be announced well in advance so that people can plan to attend.
 - Some participants thought the amount of CEU credits should be determined up front before attending in-person trainings and participating in recorded or on-line trainings. Currently, it is not clear how many credits are assigned to any given training and it is hard to know how many CEUs an individual has earned.
 - Some participants thought one person should not have the sole responsibility to determine what training is acceptable for CEUs. One option would be for the facilitators group and others to be involved in these decisions.
 - Some participants thought some agencies such as Community Alliance offer good training. These types of trainings should be recognized as eligible for CEUs.
 - Some participants thought continuing education should include specific topics such as peer support resiliency, vocational peer support, WHAM, Rent Wise, Living Well, WRAP for trauma, and smoking cessation. If people can decide what CEUs to take, they may take the path of least resistance. Determining the courses or topics up front establishes clear standards for competencies.
 - Participants were in agreement that the Transformation Transfer Initiative (TTI) focus on trauma-informed care has been a welcome addition. Many expressed the

desire for more training in this area and that this training should be required as part of CEUs.

- Some participants thought the quarterly co-supervision calls are very helpful while others thought in-person co-supervision meetings would be more beneficial than the calls. The calls sometimes include personal questions and individuals feel “put on the spot” and “humiliated.” Some people don’t feel comfortable discussing their personal issues on a call when they don’t know all of the people who may be participating on the call. Some participants indicated they did not like the directed questions by one person on the calls and “wrong” answers are corrected; they would rather have more of an open forum in which peer support specialists could have more dialogue about what works and what doesn’t. They would like more sharing of information across regions to better connect with peer support specialists across the State.
- Many respondents indicated they liked the statewide Success, Hopes and Dreams Conference. However, some thought the statewide conference seems to have grown to include more providers and administrators. While it is good these individuals are becoming more exposed to the consumer movement, there is a loss in the ability of consumers to share and connect with each other.
- Some individuals thought the Office of Consumer Affairs could do more to support local mini-conferences related to peer support. Some mentioned peer support meetings and trainings at the local level that were unattended by any staff from the Office of Consumer Affairs.
- Some participants thought the certification process should be moved to an independent peer certification board or to a state agency that does certification for other health and human services professionals, which is the model Iowa follows.

Summary and Conclusions

Results of the survey and focus groups provided useful information for peer support certification in Nebraska. Family peer support specialists thought certification would be beneficial for Nebraska. There was not a preference about the type of entity that should administer the certification process: national, state, or private. Many respondents thought certification would lend legitimacy to family peer support and help ensure that specialists are trained and qualified. A certification process should recognize the uniqueness of and be tailored to family peer support.

Many of the focus group participants thought Nebraska had made great strides in its certification process for adult peer support. Adult peer support specialists rated the Nebraska Intentional Peer Support Training (IPS) highly. Participant recommendations for improving the Nebraska IPS training include the following:

- Have more facilitators so more training can be conducted.

- Strengthen the pre-requisites for being trained in Nebraska IPS including in-person WRAP training
- Make sure Nebraska WRAP training is accessible to those in rural areas
- Some participants recommended splitting up the training across multiple weeks to avoid trainer/trainee burnout and to allow for practicing skills between sessions. Participants also recommended having three trainers for the Nebraska IPS training sessions.

Participants generally thought the testing was tough but fair. Some suggested the test be given immediately after the training so they would not have to make a separate trip to take the test.

Many participants thought it was important for the State to develop standards for continuing education units and track individuals who complete those requirements. Participants proposed a number of recommendations for improved continuing training including the following:

- Maintaining a web site with training links and recorded trainings that would count for CEUs
- Pre-determining the amount of CEU credits for particular trainings
- Determining the content of training that needs to be taken to maintain certification (e.g., trauma informed care)

Some participants thought co-supervision meetings should be conducted in person and thought a more interactive format would improve the process. A number of participants recommended greater opportunities for sharing in decision making about certification requirements such as the initial training content, the certification testing process, and continuing education requirements. Participants also expressed the desire to have greater networking mechanisms for peer support specialists.

It is also evident that there are some misperceptions about Nebraska's peer support certification process. Additional information may be helpful in communicating this process to others. A succinct summary of the process is provided by the Nebraska Department of Health and Human Services, Division of Behavioral Health, Office of Consumer Affairs and is as follows:

The Office of Consumer Affairs provides a certification as a Peer Support and Wellness Specialist from the Division of Behavioral Health within Nebraska Department of Health and Human Services. Certification includes a written and oral quiz offered to anyone with 40 hours of any peer support training. The written component takes approximately one to two hours to complete and the oral component takes approximately 30 minutes. Usually, a score can be provided on the same day. At this time, two processes are offered to the Certified Peer Support and Wellness Specialist, which are the collection of continuing education hours and participation in co-supervision, neither are required by the participant. Obtaining 6 hours of continuing education is recommended and we record all continuing education credit hours faxed to us that are related to the work of

peer support. Co-supervision is a 2 hour conference call that is recommended on a quarterly basis. Co-supervision is about two simple questions: what is working well with the 4 tasks and what is not working well with the 4 tasks of Intentional Peer Support. Participants in these calls may simply pass, if they have nothing to share. It is also a place to network with other peer specialists from across the state. We record these hours also. Currently there is no such process in place for Family Peer Specialists or Navigators, but we are open to creating needed supports. We welcome all the feedback in this report and look forward to improving our services from your feedback.

SECTION 6: CONCLUSIONS AND RECOMMENDATIONS

Nebraska has implemented a certification process for adult peer support services similar to processes used in other states. The State developed core competencies using a broad-based participatory process, selected a contractor to train trainers in Nebraska to provide the peer support training based on the competencies and created a certification process to assess the capacity of individuals to provide adult peer support services. This process meets the state's goal in trying to improve the quality of peer support services and ensure the individuals who deliver this service are appropriately trained and qualified. In this assessment of the current certification process, we did not directly observe the testing processes, nor did we statistically analyze the results from certification testing. This assessment was a qualitative review of the certification process. We conclude from our review that the current certification process appears reliable in that it is consistently administered and valid in that it relates to the objectives for which it is designed. There are written procedures for administering the certification process and the testing process appears to be administered consistently. Both the written test and the oral quiz appear to be related to the core competencies and thereby further the goals of ensuring adult peer support specialists have the capacity and skills to deliver high-quality services. Participants in the regional discussion groups made a point to note the tremendous progress Nebraska has made in recent years in developing and improving adult peer support services including the certification process. Certainly there are additional processes that could be implemented to more closely assess performance, problem solving, attitudes, and skills (see Bashook, 2005); however, the Nebraska peer support specialist certification process has achieved its goals within the available resources.

There are, however, changes that could potentially improve the current peer support certification process in Nebraska. It is important to ensure the certification process meets best practices in implementing certification standards to protect the State from legal liability and to ensure the best feasible procedures. Implementation of these enhancements must be weighed against the resources required for implementation. The following are recommended modifications to the certification process we believe would improve the process:

1. The Office of Consumer Affairs in partnership with the Nebraska Federation of Families and other stakeholders will undoubtedly continue working on a certification process for family peer support specialists. All parties recognize that family peer support specialists require a special skill set supporting families of children with serious emotional disorders. Often families they serve are involved in the 1) education system and may have an Individual Education Plan, 2) the child welfare system which may include the State as guardian and include foster parents, guardians ad litem and Court Appointed Special Advocates, 3) the juvenile justice system,

which may include probation officers, judicial proceedings, law enforcement, local juvenile detention and Youth Rehabilitation and Treatment Centers and 4) transition service systems including independent living services, supported housing and vocational rehabilitation tailored to the needs of older adolescents and young adults. Family peer support specialists assist parents and other caregivers navigate these myriad systems and may also assist caregivers access services for their own mental health and substance abuse disorders. The skills and competencies required of family peer support specialists may be similar to but somewhat different from those of adult peer support specialists. These similarities and differences will be reflected in the core competencies, the training curricula and certification process for family peer support specialists. Stakeholders have made substantial progress in developing core competencies for family peer support and thinking through issues related to certification. Survey results indicate broad support for a certification process, but there was not a preference regarding whether certification should be administered by the state, a private agency or a national organization. We recommend the Office of Consumer Affairs continue to participate in and support development of a certification process for family peer support. A certification process should recognize national best practices but also be tailored to recognize the unique culture of Nebraska.

2. Some discussion group participants suggested having Wellness Recovery Action Plan (WRAP) training as a prerequisite for the Nebraska Model of Intentional Peer Support (IPS) training. We recommend the Office of Consumer Affairs give serious consideration to this suggestion. The principles of WRAP training would appear to provide a solid foundation for the 40-hour Nebraska Model training. However, implementing this recommendation poses challenges. WRAP training is intended to be facilitated by a trainer rather than self-guided. Expanding WRAP training would require resources to train more WRAP trainers and requiring WRAP would result in additional formal training hours for Peer Support candidates beyond the 40 hours of Nebraska Model training, which could become a burden to candidates and perhaps dissuade some individuals from seeking certification. These factors must be balanced with the added skills and knowledge WRAP training would provide.
3. We recommend consideration be given to increasing the number and accessibility of Nebraska Model IPS training provided. Discussion group participants indicated that more trainings would benefit individuals interested in participating. Expanded training should be more feasible now that another cadre of trainers has been trained under Nebraska's most recent Transformation Transfer Initiative. We also recommend the Facilitator's Circle and other stakeholders be involved in considering other potential changes to improve the accessibility and quality of the Nebraska IPS

training including holding the training regionally throughout the state to increase access and reduce travel burden for individuals from rural areas, having three facilitators involved in providing each training to give more personal attention to trainees and reduce training fatigue, and splitting up the 40 hour training into multiple sessions to reduce training fatigue and allow trainees to practice skills between sessions.

4. We recommend a formal appeals and complaint process be established and documented in writing. This process would include processes to address an appeal from an individual who did not receive certification, issues raised about the certification and recertification process by individuals who are certified and complaints by individuals who receive peer support services.
5. We recommend establishing a re-certification process including requirements for continuing education credits (CEUs). Because of limited resources, the Office of Consumer Affairs (OCA) has focused on the initial certification process and provides guidance for continuing education units and co-supervision that is voluntary but not required. This creates a situation in which there is a reasonable certainty that individuals who are recently trained and certified have the skills and competencies necessary to provide high quality peer support services. However, without continuing certification or recertification requirements, individuals, who have Nebraska certification, over time may no longer have these skills and competencies. There should be clearly established standards for the number of continuing education credits required for continuing or re-certification. It may be helpful to have a broad-based participatory process to establish standards for the types of training that count toward CEUs and an objective process for determining how the number of CEUs are determined for particular training. Re-certification may also include requirements for minimum hours of practice/experience and supervision.
6. There were mixed opinions about the value of current quarterly co-supervision conference calls. This area may be another opportunity to engage peer support specialists in discussions regarding how to structure co-supervision to maximize the benefits to certified individuals. Many of the discussion group participants thought the co-supervision would be more beneficial if conducted in person and if they were more interactive than didactic. In addition, related to recommendation #5 above, we recommend co-supervision be established as a requirement for continuing certification or re-certification. If the State moves toward a "next generation" certification process through the formal regulatory process, consideration may be given to separating supervision requirements. As part of the current certification process, the Office of Consumer Affairs offers opportunities for

co-supervision to improve peer support competencies. Often as part of formal certification processes, there are requirements for formal individual supervision as a requirement for certification. We suggest that both types of supervisory processes can be combined to help ensure peer support specialists have the skills and capabilities to provide high quality peer support services.

7. We recommend establishing procedures for revoking certification and handling complaints about certified peer support specialists. Peer support specialists should be required to sign a statement to inform certification officials about any conditions that may compromise their ability to perform high-quality peer support and to discontinue claims to certification upon revocation. Conditions for revoking certification should be clearly established in written policy. The State should develop the capacity to track ongoing certification requirements and investigate consumer complaints and situations that may affect the capacity of the certified person to provide peer support services. Procedures should include qualifications of investigative staff, timelines for investigations, procedures for making decisions and communicating results, and procedures for appealing decisions.
8. We recommend ongoing evaluation of the certification process through a continuous quality improvement process. The evaluation should include ongoing analysis of training satisfaction and improvement surveys, monitoring of trainings to ensure consistency and quality, ongoing review and updating of the training curriculum to ensure up-to-date research results and best practices are incorporated, regular input from certified individuals about how the certification process can be improved, and periodic management audits to assess the degree to which all components of the certification process are working as designed. Modifications to the certification process resulting from the evaluation should be documented. One special note of interest is how well the certification process works for peer support specialists working in the areas of substance abuse and addiction; continuing discussions with stakeholders involved in this area will be beneficial.
9. We recommend moving from the current peer support certification process to a next generation certification process through the formal regulations process. This next generation process includes checks and balances including ensuring public input into the certification process, formalizing written standards, and ensuring consistency with Nebraska statutory authority. The move to formal regulatory procedures ensures the certification process has the force of law and allows certification procedures to be enforced. Continued stakeholder input can be formalized through an advisory committee, established through regulations, to oversee the certification process. Moving toward a formalized certification process helps enhance protections of

consumers of peer support services and increases protections for peer support specialists as well. We recognize that a formal certification process will require additional resources to effectively implement compared to the current process.

10. On a longer term basis, the Office of Consumer Affairs should consider separation of the training and certification processes. All certification processes in other states we reviewed are linked to a training curriculum established or adopted by the state. This seems to be a natural starting point for certification development – identifying core competencies, developing a training curriculum that incorporates these competencies, and establishing a certification process that tests knowledge related to the competencies included in the training. State mental health authorities tend to be the entities in the best position to develop all three of these processes. However, once these procedures are established, it may be beneficial to separate these functions as part of the natural evolution of a maturing certification process. Generally, states have an entity responsible for certifying different types of health care professionals. Placing the responsibility of certifying peer support specialists with this entity is likely to elevate the prestige of peer support certification and avoid potential conflicts of interest when an agency has responsibility for both training and certification.

11. Consider how the competencies of peer support specialists fit with and differ from competencies of other mental health and substance abuse professions to ensure quality and harmony across professionals. Scholars have suggested a basic set of competencies across all professionals working with individuals with mental health and substance abuse challenges (e.g., Hoge et.al, 2009) including shared methods to identify and assess competency, competencies to address co-occurring disorders, competencies to work as multidisciplinary team members and as system partners, competencies to focus on preventative and resiliency-focused models of care, and competencies related to cultural and linguistic competence. As Nebraska moves forward with its certification process for peer support specialists, we recommend attending to the larger effort to build cross-professional competencies for behavioral health disciplines and ensure requirements for peer support conform and build upon these broader initiatives. Similarly, we recommend continuously assessing Nebraska's peer support certification process in the context of national peer support program accreditation efforts.

In addition, we recognize the field of peer support credentialing is evolving. Many states have certification processes, and there are discussions about national certification. As Nebraska moves toward its next generation peer support

certification process, issues about how to recognize peer support certifications from other states and from national credentialing organizations will need to be addressed.

12. Multiple sources currently fund or could fund peer support services. Currently, the DHHS Division of Behavioral Health and Division of Children and Family Services fund peer support in Nebraska. Medicaid and private insurance carriers are examples of entities that could fund peer support in the future. As the Office of Consumer Affairs and other stakeholders address issues surrounding certification of peer support and wellness specialists, these other funders and potential funders should be engaged in the dialogue about standards and core competencies to ensure the needs of each funding system are met and to develop a more comprehensive model of peer support that can be financially sustained.

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F.



Nebraska Peer Support Focus Group/Survey Report

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Nebraska Peer Support Focus Group/Survey Report

The University of Nebraska Public Policy Center conducted a survey and focus groups in each of the behavioral health regions of Nebraska during September and October 2013. There were four groups that participated in the surveys and focus groups: Adult peer support specialists, family peer support specialists, consumers of adult peer support, and consumers of family peer support. Included in both the surveys and focus groups were questions about 1) demographics, 2) trauma experience as assessed by two standardized instruments: a) the Posttraumatic Growth Inventory and b) the Post Traumatic Stress Disorder (PTSD) Checklist , 3) consumer satisfaction with peer support services, and 4) the practice of peer support including Nebraska's peer support certification process. It should be kept in mind this report summarizes the responses of participants in the focus groups and surveys and reflects the consumer voice; the University of Nebraska has not endorsed the recommendations proposed nor verified the accuracy of statements made. Results pertaining to certification are included in a separate report and not included in this report. The results for the other areas of inquiry explored by the surveys and focus groups are discussed separately below.

Survey Results

Demographic Information

There were 146 respondents to the survey. The largest response group was adult consumers (see Table 1).

Table 1: Number of Survey Participants by Respondent Type

| | Adult Consumer | Family Consumer | Adult Peer Specialist | Family Peer Specialist |
|--|-----------------------|------------------------|------------------------------|-------------------------------|
| Overall number of valid surveys | 70 | 34 | 16 | 26 |

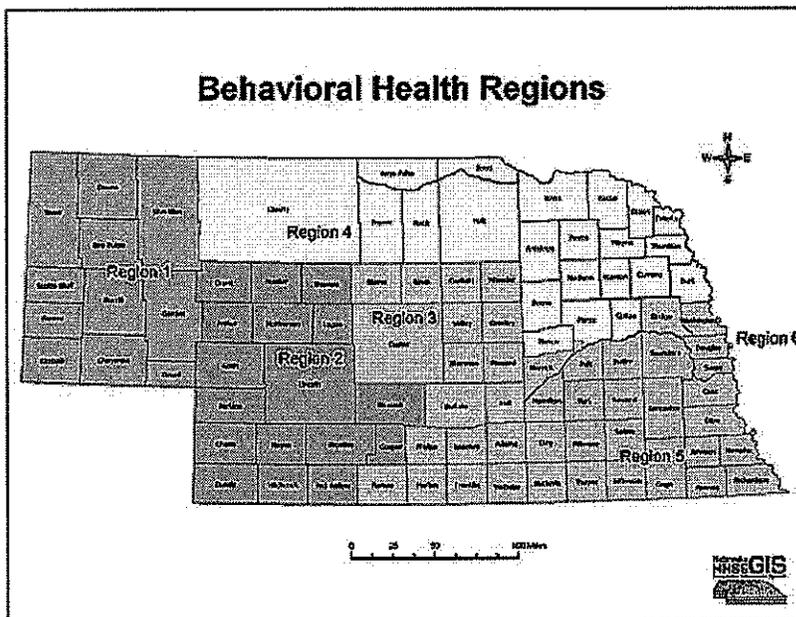
Table 2 shows the demographic characteristics for each of the four respondent groups. Most respondents were female, white and non-Hispanic. There were wide disparities in participation across regions. For example, there were no consumer surveys completed in Region 6 even though the largest proportion of the population lives in that region, while over 80% of the adult consumer surveys were completed by consumers in Regions 2 and 3, two rural regions of the State.

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Table 2: Demographic Characteristics by Survey Respondents by Respondent Group

| | Adult Consumer | Family Consumer | Adult Peer Specialist | Family Peer Specialist |
|-----------------------------------|-----------------------|------------------------|------------------------------|-------------------------------|
| Gender | | | | |
| Female | 65.7% (46) | 85.3% (29) | 87.5% (14) | 92.3% (24) |
| Male | 34.3% (24) | 14.7% (5) | 12.5% (2) | 7.7% (2) |
| Ethnicity | | | | |
| Hispanic | 3.0% (2) | 21.2% (7) | 0% (0) | 4.2% (1) |
| Non-Hispanic | 97.0% (65) | 78.8% (26) | 100% (16) | 95.8% (23) |
| Race | | | | |
| African American / Black | 1.4% (1) | 3.1% (1) | 0% (0) | 0% (0) |
| Asian / Pacific Islander | 0% (0) | 0% (0) | 0% (0) | 0% (0) |
| Caucasian / White | 92.8% (64) | 90.6% (29) | 100% (16) | 84.6% (22) |
| Native American / American Indian | 2.9% (2) | 3.1% (1) | 0% (0) | 3.8% (1) |
| Multiracial or Other | 2.9% (2) | 3.1% (1) | 0% (0) | 11.5% (3) |
| Location | | | | |
| Region 1 | 10.3% (7) | 10.0% (3) | 7.1% (1) | 8.3% (2) |
| Region 2 | 35.3% (24) | 23.3% (7) | 7.1% (1) | 20.8% (5) |
| Region 3 | 48.5% (33) | 0.0% (0) | 7.1% (1) | 25.0% (6) |
| Region 4 | 4.4% (3) | 20.0% (6) | 28.6% (4) | 0% (0) |
| Region 5 | 1.5% (1) | 46.7% (14) | 42.9% (6) | 37.5% (9) |
| Region 6 | 0% (0) | 0% (0) | 7.1% (1) | 8.3% (2) |

The Behavioral Health Regions are shown in Figure 1:



Trauma

All four respondent group surveys included the two trauma scales, although for a substantial number of surveys, consumers either did not receive the trauma scales or declined to complete them. The purpose for administering the trauma scales was to determine the level of trauma experienced by consumers and peer support specialists, and to determine the potential utility of using the scales to assess trauma on an ongoing basis as part of the peer support programs. Information from the two scales could be used to 1) help guide peer support interventions and referrals and 2) evaluate changes in adaptations and problems resulting from trauma, and hence serve as an evaluation tool for peer support services. Table 3 shows the incidence of trauma for the four respondent groups. All adult and family peer support specialists reported having experienced trauma; over 90% of each group had experienced personal trauma, and over 75% of each group had experienced vicarious trauma and/or compassion fatigue. Approximately 85% of adult and family consumers who completed this section of the survey had experienced trauma; adult consumers were more likely to experience personal trauma than family consumers.

Table 3: Trauma Experienced by Respondent Group and Type of Trauma

| | Adult Consumer | Family Consumer | Adult Peer Specialist | Family Peer Specialist |
|---------------------------|-----------------------|------------------------|------------------------------|-------------------------------|
| Trauma | 81.1% (30) | 70.6% (24) | 93.8% (15) | 96.2% (25) |
| Vicarious Trauma | 45.7% (16) | 47.1% (16) | 87.5% (14) | 76.0% (19) |
| Compassion Fatigue | 54.1% (20) | 57.6% (19) | 75.0% (12) | 80.8% (21) |
| Any Trauma | 84.2% (32) | 85.3% (29) | 100% (16) | 100% (26) |

Table 4 shows responses for each item for the Posttraumatic Growth Inventory. These questions were asked only of people reporting any kind of traumatic experience. For each item, the following scale was used:

- 0= Did not experience
- 1= Very small degree
- 2= Small degree
- 3=Moderate degree
- 4= Great degree
- 5= Very great degree

Ratings of 3 or higher indicate moderate or greater change. We examined the distribution of scores for each item by respondent group, the distribution of total scores by group and the number of individuals who entered maximum scores for all items (possibly indicating the respondent did not consider each item individually). All items have acceptable or good distributions, and the scale Total Score has a good distribution. The proportion of individuals providing maximum scores for all items was within acceptable standards. We expected adult

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and family peer support specialists to show greater adaptation to trauma, and the survey results support this hypothesis; total scores for adult and family peer support specialists were about 10 points higher than scores for adult and family consumers.

Table 4: Average Scores and (Standard Deviations) for each Item on the Posttraumatic Growth Inventory by Respondent Group

| Response | Adult Consumer (N=32) | Family Consumer (N=29) | Adult Specialist (N=16) | Family Specialist (N=26) | All Groups Combined |
|--|------------------------------|-------------------------------|--------------------------------|---------------------------------|------------------------------|
| 1. I changed my priorities about what is important in life. | 3.31 (1.53) | 4.00 (1.16) | 3.87 (1.46) | 3.85 (1.12) | 3.72 (1.34) |
| 2. I have a greater appreciation for the value of my own life. | 3.50 (1.52) | 3.90 (1.35) | 4.20 (1.21) | 4.08 (1.38) | 3.86 (1.40) |
| 3. I developed new interests. | 3.00 (1.44) | 3.34 (1.52) | 3.47 (1.73) | 3.38 (1.47) | 3.26 (1.50) |
| 4. I have a greater feeling of self-reliance. | 3.23 (1.31) | 3.62 (1.40) | 3.33 (1.63) | 3.77 (1.39) | 3.50 (1.40) |
| 5. I have a better understanding of spiritual matters. | 3.47 (1.52) | 3.21 (1.70) | 4.00 (1.25) | 3.62 (1.44) | 3.51 (1.52) |
| 6. I more clearly see that I can count on people in times of trouble. | 2.88 (1.45) | 2.90 (1.66) | 3.40 (1.40) | 3.31 (1.54) | 3.07 (1.52) |
| 7. I established a new path for my life. | 3.31 (1.40) | 3.76 (1.24) | 3.80 (1.27) | 3.81 (1.33) | 3.64 (1.32) |
| 8. I have a greater sense of closeness with others. | 2.56 (1.74) | 2.59 (1.82) | 3.40 (1.40) | 3.19 (1.47) | 2.85 (1.67) |
| 9. I am more willing to express my emotions. | 2.97 (1.81) | 2.69 (1.82) | 3.47 (1.51) | 2.92 (1.41) | 2.95 (1.67) |
| 10. I know I can handle difficulties better. | 2.75 (1.50) | 3.28 (1.49) | 4.20 (1.15) | 4.15 (1.05) | 3.47 (1.46) |
| 11. I am able to do better things with my life. | 3.28 (1.51) | 3.17 (1.51) | 4.07 (1.03) | 3.92 (1.16) | 3.53 (1.40) |
| 12. I am better able to accept the way things work out. | 2.78 (1.21) | 2.83 (1.51) | 3.80 (1.01) | 3.65 (1.06) | 3.17 (1.31) |
| 13. I can better appreciate each day. | 3.53 (1.30) | 3.41 (1.50) | 4.13 (1.13) | 3.88 (1.24) | 3.68 (1.33) |
| 14. New opportunities are available which would not have been otherwise. | 3.31 (1.31) | 2.59 (1.86) | 3.80 (1.15) | 3.58 (1.53) | 3.25 (1.56) |
| 15. I have more compassion for others. | 3.39 (1.63) | 3.59 (1.32) | 4.13 (1.13) | 4.35 (0.69) | 3.80 (1.32) |
| 16. I put more effort into my relationships. | 3.13 (1.48) | 3.28 (1.73) | 3.60 (1.55) | 3.52 (1.19) | 3.34 (1.49) |
| 17. I am more likely to try to change things which need changing. | 3.09 (1.33) | 3.48 (1.55) | 3.93 (1.03) | 4.00 (0.75) | 3.56 (1.28) |
| 18. I have a stronger religious faith. | 3.09 (1.69) | 2.90 (1.92) | 3.47 (1.92) | 3.19 (1.83) | 3.12 (1.81) |

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| Response | Adult Consumer (N=32) | Family Consumer (N=29) | Adult Specialist (N=16) | Family Specialist (N=26) | All Groups Combined |
|--|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| 19. I discovered I am stronger than I thought I was. | 3.28 (1.49) | 4.00 (1.31) | 4.20 (1.15) | 4.50 (0.95) | 3.93 (1.34) |
| 20. I learned a great deal about how wonderful people are. | 2.94 (1.70) | 2.72 (1.96) | 3.33 (1.40) | 3.38 (1.33) | 3.05 (1.66) |
| 21. I better accept needing others. | 2.94 (1.74) | 2.93 (1.62) | 3.47 (1.41) | 2.85 (1.41) | 2.99 (1.57) |
| TOTAL SCORE* (score range = 0 – 105) | 66.97 (22.90) | 68.39 (25.12) | 79.07 (21.26) | 77.16 (14.97) | 71.83 (21.89) |
| Scored all '5's | 3.3% (n=1) | 7.1% (n=2) | 6.7% (n=1) | 4.0% (n=1) | 5.1% (n=5) |

To assess problems resulting from trauma, we used the Post Traumatic Stress Disorder (PTSD) Checklist and added one item about increased drug and alcohol abuse. Table 5 shows responses for each item for the scale. These questions were asked only of people reporting any kind of traumatic experience. For each item, the following scale was used:

- 1= Not at all
- 2= A little bit
- 3= Moderately
- 4= Quite a bit
- 5= Extremely

Ratings of 3 or higher indicate moderate or greater change. We examined the distribution of scores for each item by respondent group, the distribution of total scores by group and the number of individuals who entered maximum scores for all items (possibly indicating the respondent did not consider each item individually). All items except one have acceptable or good distributions, and the scale Total Score (without item 18) has a good distribution (Total score is computed only for people who answered all of the first 17 questions). The exception is item 18 which is not part of the standard scale; it is highly skewed, with 86% of participants choosing a scale value of 1 – Not at all. The proportion of individuals providing maximum scores for all items was within acceptable standards. We expected adult and family peer support specialists to show fewer problems related trauma, and the survey results support this hypothesis; total scores for adult and family peer support specialists were lower than scores for adult and family consumers.

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Table 5: Average Scores and (Standard Deviations) for each Item on the PTSD Scale by Respondent Group

| Response | Adult Consumer (N=32) | Family Consumer (N=29) | Adult Specialist (N=16) | Family Specialist (N=26) | All Groups Combined |
|---|-----------------------|------------------------|-------------------------|--------------------------|---------------------|
| 1. I have repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past. | 3.61 (1.31) | 3.03 (1.45) | 2.67 (1.18) | 2.50 (1.07) | 3.02 (1.33) |
| 2. I have repeated, disturbing <i>dreams</i> of a stressful experience from the past. | 3.35 (1.54) | 2.55 (1.55) | 2.80 (1.21) | 2.12 (1.21) | 2.72 (1.48) |
| 3. I suddenly <i>act or feel</i> as if a stressful experience were <i>happening again</i> (as if I am reliving it). | 3.03 (1.45) | 2.38 (1.50) | 2.20 (1.15) | 2.08 (1.09) | 2.48 (1.38) |
| 4. I feel <i>very upset</i> when <i>something reminds</i> me of a stressful experience from the past. | 3.77 (1.12) | 2.93 (1.62) | 2.73 (1.03) | 2.23 (1.14) | 2.98 (1.39) |
| 5. I have <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when something reminds me of a stressful experience from the past. | 3.68 (1.42) | 2.69 (1.54) | 3.00 (1.07) | 2.42 (1.24) | 2.97 (1.44) |
| 6. I avoid <i>thinking about or talking about</i> a stressful experience from the past or avoid having feelings related to it. | 3.71 (1.19) | 2.48 (1.54) | 2.60 (1.40) | 2.27 (1.28) | 2.82 (1.43) |
| 7. I avoid <i>activities or situations</i> because they remind me of a stressful experience from the past. | 3.63 (1.27) | 2.28 (1.39) | 2.73 (1.39) | 2.50 (1.36) | 2.81 (1.44) |
| 8. I have <i>trouble remembering important parts</i> of a stressful experience from the past. | 3.07 (1.34) | 2.29 (1.49) | 2.67 (1.45) | 2.23 (1.39) | 2.57 (1.44) |
| 9. I have <i>loss of interest in things I used to enjoy</i> . | 3.27 (1.44) | 2.62 (1.40) | 2.20 (1.01) | 1.85 (1.29) | 2.55 (1.42) |
| 10. I feel <i>distant or cut off</i> from other people. | 3.10 (1.61) | 2.96 (1.37) | 2.00 (1.25) | 1.88 (1.18) | 2.57 (1.47) |
| 11. I feel <i>emotionally numb</i> or unable to have loving feelings for those close to me. | 2.97 (1.49) | 2.14 (1.38) | 1.79 (0.89) | 1.62 (0.94) | 2.21 (1.36) |
| 12. I feel as if my <i>future</i> will somehow be <i>cut short</i> . | 2.87 (1.46) | 2.00 (1.34) | 2.13 (1.60) | 1.38 (0.90) | 2.12 (1.42) |
| 13. I have <i>trouble falling or staying asleep</i> . | 3.55 (1.23) | 2.97 (1.61) | 2.57 (1.40) | 2.46 (1.53) | 2.96 (1.50) |
| 14. I feel <i>irritable</i> or have <i>angry outbursts</i> . | 2.83 (1.42) | 2.48 (1.27) | 1.93 (1.10) | 1.92 (1.16) | 2.36 (1.31) |
| 15. I have <i>difficulty concentrating</i> . | 3.42 (1.18) | 3.14 (1.43) | 2.67 (1.29) | 2.19 (1.17) | 2.91 (1.34) |

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| Response | Adult Consumer (N=32) | Family Consumer (N=29) | Adult Specialist (N=16) | Family Specialist (N=26) | All Groups Combined |
|---|--|--|---|---|--|
| 16. I am "super alert" or watchful on guard. | 3.26 (1.26) | 3.07 (1.49) | 2.67 (1.35) | 2.08 (1.20) | 2.81 (1.39) |
| 17. I feel jumpy or easily startled. | 3.52 (1.15) | 2.45 (1.53) | 2.60 (1.45) | 1.65 (0.94) | 2.59 (1.44) |
| ^18. I have increased my use of alcohol or drugs. | 1.71 (1.30) | 1.07 (0.37) | 1.07 (0.26) | 1.12 (0.43) | 1.28 (0.83) |
| TOTAL SCORE* (minus item 18) (score range = 17 – 85; problem score > 50) | 58.04 (15.74) >50 n=16 | 45.77 (19.01) >50 n=11 | 38.23 (10.41) >50 n=2 | 35.38 (14.64) >50 n=5 | 45.23 (18.05) >50 n=34 |
| Scored all '5's | 3.8% (n=1) | 0% (n=0) | 0% (n=0) | 0% (n=0) | 1.1% (n=1) |

^Item 18 was not part of the original scale

Both trauma scales would seem to have utility as initial screening/assessment and ongoing evaluation tools.

Consumer Satisfaction

Adult and family consumers of peer support services were asked about their level of satisfaction about peer support services on a number of dimensions: Access, Quality and Appropriateness, Perceived Outcomes, Response, Participation in Service Planning, General Satisfaction, Ability to Cope, and Social Connectedness. Table 6 shows responses to the satisfaction survey by respondent group and for each subscale. For each item, the following scale was used:

1= Strongly disagree

2= Disagree

3= Neither agree nor disagree

4= Agree

5= Strongly agree

All consumer satisfaction items were examined for acceptable distributions. One item fell outside the standard acceptable level for skewness: Access #1 has 94.8% of participants selecting either Agree or Strongly Agree. Several items also fell outside acceptable levels for kurtosis (peakedness) of the distribution: Access #4; Quality #2, Quality #3, Quality #5; Outcomes #1, Outcomes #2; Participation #2; All General items: General #1, General #2, General #3; and Social #1, and Social #2. All other items have acceptable distributions.

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For the average domain scores, all domain averages had an acceptable degree of skewness, but only Participation in Service Planning, General Satisfaction, and Social Connectedness had an acceptable degree of kurtosis. General Satisfaction items received no '1' ratings, however, so the full range of the scale for this domain was not utilized by participants. The cause of the remaining average domain scores not having acceptable distributions was because a large percentage of people scored the items within the domain with all 4's or all 5's, and very few provided scores at the lower end of the scale range. If the satisfaction surveys are to be used for program evaluation, the "Participation in Service Planning" and "Social Connectedness" subscales would appear to offer some degree of utility.

Table 6: Average Scores and (Standard Deviations) Items and Subscales for the Satisfaction Survey by Respondent Group

| Response | Adult Consumer | Family Consumer | All Consumers |
|---|-----------------------|------------------------|----------------------|
| Access | | | |
| 1. The location of services was convenient (parking, public transportation, distance, etc.). | 4.56 (0.58) | 4.37 (0.85) | 4.46 (0.73) |
| 2. Staff were willing to see me/us as often as I felt it was necessary. | 4.26 (0.94) | 4.38 (1.02) | 4.32 (0.97) |
| 3. Staff returned my/our calls in 24 hours. | 3.70 (0.87) | 4.26 (1.26) | 3.98 (1.11) |
| 4. Services were available at times that were good for me/us. | 4.39 (0.74) | 4.28 (1.03) | 4.33 (0.89) |
| 5. I/We was/were able to get all the services I/we thought I/we needed. | 4.39 (0.69) | 3.97 (1.24) | 4.18 (1.02) |
| 6. I/We was/were able to see a peer support specialist when I/we wanted to. | 4.14 (0.93) | 4.17 (1.21) | 4.16 (1.07) |
| Average Access Score | | | 4.22 (0.81) |
| Scored all '5's | | | 25.9% (n=15) |
| Averaged greater than '3' | | | 93.2% (n=54) |
| Averaged '3' or lower | | | 6.8% (n=4) |
| Quality and Appropriateness | | | |
| 1. I felt free to complain. | 3.89 (0.96) | 4.13 (1.17) | 3.98 (1.03) |
| 2. Staff respected my/our wishes about who is and who is not to be given information about my [child's] services. | 4.21 (1.02) | 4.38 (0.98) | 4.26 (1.01) |
| 3. Staff here believe I/we can grow, change and recover. | 4.30 (0.94) | 4.40 (0.89) | 4.33 (0.92) |
| 4. Staff were sensitive to my/our cultural background (race, religion, language, etc.). | 4.08 (0.95) | 4.14 (1.09) | 4.10 (1.00) |
| 5. Staff helped me/us obtain the information I/we needed so I/we could take charge of managing my/our [child's] recovery. | 4.30 (0.93) | 4.21 (1.05) | 4.27 (0.96) |
| 6. I/We was/were encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.). | 4.20 (0.87) | 4.30 (0.92) | 4.24 (0.88) |
| Average Quality Score | | | 4.19 (0.74) |
| Scored all '5's | | | 23.3% (n=21) |
| Averaged greater than '3' | | | 92.3% (n=83) |

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| Response | Adult Consumer | Family Consumer | All Consumers |
|---|----------------|-----------------|---------------|
| Averaged '3' or lower | | | 7.7% (n=7) |
| Outcomes. As a direct result of services received: | | | |
| 1. I/We deal more effectively with daily problems. | 4.00 (0.82) | 3.83 (1.02) | 3.94 (0.89) |
| 2. I/We am/are better able to control my/our life/lives. | 3.98 (0.84) | 3.83 (1.02) | 3.93 (0.90) |
| 3. I/We am/are better able to deal with crisis. | 3.76 (1.01) | 3.93 (1.08) | 3.82 (1.03) |
| 4. I am getting/We get along better with/in my/our family. | 3.69 (1.04) | 3.63 (1.25) | 3.67 (1.11) |
| 5. I/We do better in social situations. | 3.68 (0.95) | 3.87 (1.11) | 3.74 (1.00) |
| 6. I/We do better in school and/or work. | 3.43 (1.15) | 3.57 (1.07) | 3.48 (1.12) |
| 7. My/Our housing situation has improved. | 3.86 (1.07) | 3.90 (1.11) | 3.88 (1.08) |
| 8. My/mental health symptoms are not bothering me/us as much. | 3.79 (0.86) | 3.53 (1.20) | 3.70 (0.99) |
| Average Outcomes Score | | | 3.78 (0.77) |
| Scored all '5's | | | 8.9% (n=8) |
| Averaged greater than '3' | | | 87.9% (n=79) |
| Averaged '3' or lower | | | 12.1% (n=11) |
| Participation in Treatment (service) planning | | | |
| 1. I felt comfortable asking questions about my [child's] recovery and [family] peer support. | 3.88 (1.09) | 4.33 (0.92) | 4.03 (1.05) |
| 2. I/We, not staff, decided my/our recovery goals. | 4.09 (0.94) | 4.27 (0.91) | 4.15 (0.93) |
| ^Average Participation Score | | | 4.09 (0.88) |
| Scored all '5's | | | 34.4% (n=31) |
| Averaged greater than '3' | | | 81.1% (n=73) |
| Averaged '3' or lower | | | 18.9% (n=17) |
| General Satisfaction | | | |
| 1. I/We like the services I/we received here. | 4.43 (0.62) | 4.45 (0.96) | 4.43 (0.75) |
| 2. If I had other choices, I would still get services from this agency. | 4.30 (0.80) | 4.55 (0.77) | 4.38 (0.80) |
| 3. I would recommend this agency to a friend or family member. | 4.36 (0.82) | 4.55 (0.77) | 4.42 (0.80) |
| Average General Score | | | 4.41 (0.65) |
| Scored all '5's | | | 43.5% (n=40) |
| Averaged greater than '3' | | | 93.4% (n=86) |
| Averaged '3' or lower | | | 6.6% (n=6) |
| Ability to Cope. As a Direct Result of Services I Received: | | | |
| 1. My symptoms are not bothering me as much./ We are better able to address our child's symptoms. | 3.78 (0.89) | 4.16 (1.13) | 3.91 (0.99) |
| 2. I/We do things that are more meaningful to me/us. | 4.08 (0.82) | 4.10 (1.08) | 4.09 (0.91) |
| 3. I/We am/are better able to take care of my/our needs. | 4.02 (0.77) | 4.03 (1.17) | 4.02 (0.92) |
| 4. I/We am/are better able to handle things when they go wrong. | 3.78 (1.02) | 3.97 (1.08) | 3.84 (1.04) |
| 5. I/We am/are better able to do the things I/we want to do. | 4.00 (0.91) | 3.90 (1.19) | 3.97 (1.01) |
| 6. I/We am/are better able to handle school/work. | 3.63 (1.02) | 3.77 (1.09) | 3.68 (1.04) |
| 7. I/We am/are better able to participate in social/recreational activities. | 4.02 (0.82) | 3.87 (1.12) | 3.97 (0.93) |

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| Response | Adult Consumer | Family Consumer | All Consumers |
|---|-----------------------|------------------------|----------------------|
| Average Coping Score | | | 3.93 (0.83) |
| Scored all '5's | | | 15.4% (n=14) |
| Averaged greater than '3' | | | 89.0% (n=81) |
| Averaged '3' or lower | | | 11.0% (n=10) |
| Social Connectedness | | | |
| 1. I am happy with the friendships I have. | 4.17 (0.87) | 3.74 (1.24) | 4.02 (1.02) |
| 2. I have people with whom I can do enjoyable things. | 4.07 (0.97) | 4.16 (0.93) | 4.10 (0.96) |
| 3. I feel I belong to my community. | 3.83 (1.09) | 3.61 (1.23) | 3.76 (1.14) |
| 4. In a crisis, I would have the support I need from family or friends. | 3.88 (1.01) | 3.71 (1.22) | 3.82 (1.08) |
| ^Average Social Score | | | 3.93 (0.90) |
| Scored all '5's | | | 19.8% (n=18) |
| Averaged greater than '3' | | | 83.5% (n=86) |
| Averaged '3' or lower | | | 16.5% (n=15) |

Peer Support Services

We asked adult and family peer support specialists about their work. Table 7 provides the results for both respondent groups. A small percentage of respondents in both groups provided peer support services full time. A greater proportion of adult peer support specialists than family peer support specialists spent 50% or less of their time providing peer support; however the results of this question are difficult to interpret. It is unclear whether participants answered this question based on 1) their total time available (hence 50% would mean they work half time in peer support), 2) their total work time (hence 50% would mean they work 50% in peer support and 50% in other areas), or 3) the percentage of time they do face to face peer support as opposed to other activities such as administration. We recommend this question be modified or eliminated in future surveys.

Both respondent groups reported working with individuals with mental health or co-occurring mental health and substance abuse problems; no respondents reported working with primarily individuals with substance abuse challenges. The majority of peer support specialists in both groups reporting making between \$10 and \$20 per hour. No one reported making \$30 or more per hour. The majority of respondents in both groups reported having five years or less experience.

There were a variety of terms used to label peer support specialists: nearly 27% of adult peer support specialists were called "Peer Support and Wellness Specialists," and about 54% of family peer support specialists were called "Family Advocates." Adult peer support specialists worked for a variety of organization types including service provider organizations, consumer organizations, and behavioral health regions; family peer support specialists worked primarily for family organizations.

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Table 7: Response Percentages and (Number) for Adult and family Peer Support Specialists

| | Adult Peer Specialist | Family Peer Specialist |
|--|------------------------------|-------------------------------|
| What proportion of your work time do you currently spend providing peer support services? | | |
| 0-25% | 14.3% (2) | 8.3% (2) |
| 26-50% | 35.7% (5) | 12.5% (3) |
| 51-75% | 7.1% (1) | 25.0% (6) |
| 76-99% | 28.6% (4) | 37.5% (9) |
| 100% | 14.3% (2) | 16.7% (4) |
| What proportion of your time is spent working with individuals with mental health and/or substance abuse issues? | | |
| Mostly mental health | 40.0% (6) | 36.4% (8) |
| Mostly substance abuse | 0% (0) | 0% (0) |
| Mostly co-occurring mental health and substance abuse | 26.7% (4) | 40.9% (9) |
| Equally divided among mental health, substance abuse and co-occurring disorders | 33.3% (5) | 22.7% (5) |
| What is the average hourly rate you are paid for peer support services? | | |
| \$0 | 15.4% (2) | 0% (0) |
| \$1-\$10/hour | 7.7% (1) | 29.2% (7) |
| \$11-\$20/hour | 69.2% (9) | 62.5% (15) |
| \$21-\$30/hour | 7.7% (1) | 8.3% (2) |
| Over \$30/hour | 0% (0) | 0% (0) |
| How many years have you provided peer support services? | | |
| 0-5 years | 66.7% (10) | 66.7% (16) |
| 5-10 years | 26.7% (4) | 20.8% (5) |
| 10-15 years | 0% (0) | 8.3% (2) |
| Over 15 years | 6.7% (1) | 4.2% (1) |
| What is your job title? | | |
| Peer Support and Wellness Specialist | 26.7% (4) | 0% (0) |
| Peer Specialist (asked only of Adult Specialists) | 6.7% (1) | |
| Navigator (asked only of Adult Specialists) | 0% (0) | |
| Recovery Specialist (asked only of Adult Specialists) | 6.7% (1) | |
| Advocate (asked only of Adult Specialists) | 0% (0) | |
| Family Peer Support Specialist (asked only of Family Specialists) | | 4.2% (1) |
| Family Navigator (asked only of Family Specialists) | | 8.3% (2) |
| Family Partner (asked only of Family Specialists) | | 0% (0) |
| Family Advocate (asked only of Family Specialists) | | 54.2% (13) |
| Other (please specify) | 60.0% (9) | 33.3% (8) |
| <i>Adult Peer Specialists</i> | | |
| <ul style="list-style-type: none"> • Certified Peer Support and Wellness Specialist for Employment • Consumer Specialist • Consumer Specialist Peer Recovery Facilitation • Peer Companion [2 responses] • Peer Employment Specialist | | |

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| | Adult Peer Specialist | Family Peer Specialist |
|---|-----------------------|------------------------|
| <ul style="list-style-type: none"> Peer Support Specialist [2 did not specify] <p><i>Family Peer Specialists</i></p> <ul style="list-style-type: none"> administration Executive Director [2 responses] Family Advocate and Office Manager Family advocate, program manager Family Navigator and Family Advocate Review Specialist Services Coordinator; Family Support Worker | | |
| Do you supervise other peer support specialists? | | |
| Yes | 26.7% (4) | 41.7% (10) |
| No | 73.3% (11) | 58.3% (14) |
| How would you characterize the agency you work for? | | |
| Community Mental Health Agency | 6.7% (1) | 4.2% (1) |
| Hospital | 0% (0) | 0% (0) |
| Consumer Organization | 26.7% (4) | 4.2% (1) |
| Family Organization | 0% (0) | 87.5% (21) |
| Behavioral Health Region | 20.0% (3) | 0% (0) |
| Independent (provide services on your own) | 6.7% (1) | 0% (0) |
| Other (please specify) | 40.0% (6) | 4.2% (1) |
| <p><i>Adult Peer Specialists</i></p> <ul style="list-style-type: none"> Adult Day Program Community Mental Health Agency and Omaha Police Hospital, non-profit Mental Health & Substance Abuse Non-profit organization [2 responses] <p><i>Family Peer Specialists</i></p> <ul style="list-style-type: none"> Oversight Agency | | |

Training

We asked adult and family peer support specialists about training and experience using the following scale:

- 1= Not valuable
- 2= A little valuable
- 3= Quite valuable
- 4= Very valuable

Table 8 shows the results. Responses are reported only for those who indicated they attended the particular training. All trainings attended by adult and family peer support specialists were

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considered quite to very valuable. One’s own life experience was highly rated for each of the respondent groups.

Table 8: Rating and (Standard Deviation) for Various Trainings by respondent Group

| Training | Adult Peer Specialist | Family Peer Specialist |
|--|------------------------------|-------------------------------|
| Nebraska Intentional Peer Support training | 3.47 (0.74), n=15 | 3.14 (0.96), n=7 |
| National Intentional Peer Support training | 4.00 (0.00), n=2 | 3.50 (0.84), n=6 |
| Other national peer support training | 3.50 (0.55), n=6 | 3.70 (0.48), n=10 |
| Other state/regional peer support training | 3.20 (0.92), n=10 | 3.47 (0.80), n=17 |
| Other peer support training from your agency | 3.60 (0.70), n=10 | 3.52 (0.68), n=21 |
| Own life experience | 4.00 (0.00), n=15 | 3.83 (0.39), n=23 |
| Experience working with consumers | 3.80 (0.42), n=15 | 3.83 (0.39), n=23 |

For Adult Peer Support Specialists, we asked how valuable training would be for the core adult peer support competency areas identified in the State of Nebraska. The following scale was used:

- 1= Not valuable
- 2= A little valuable
- 3= Quite valuable
- 4= Very valuable

Table 9 shows the results. The average rating for each of the competencies was between quite valuable and very valuable and ranged from a lows of 3.21 for “The power of language” and 3.23 for “Consciousness raising/critical learning” to a high of 3.64 for “mutual responsibility: belief in the poser of relationship” and “shared risk (e.g., ability to negotiate fear, anger, conflict).

Table 9: Adult Peer Support Specialist Ratings of Value and (Standard Deviation) of Need for Training in Core Competency Areas by Respondent Group

| Competency Areas | Adult Peer Specialist |
|---|------------------------------|
| 1. Commitment to recovery, growth, evolution, inspiring hope | 3.57 (0.65) |
| 2. Personal and relational accountability | 3.29 (0.83) |
| 3. The power of language (e.g., using language free of jargon, judgments, etc.) | 3.21 (0.80) |
| 4. Direct honest respectful communication | 3.36 (0.75) |
| 5. Consciousness raising/critical learning | 3.23 (0.73) |
| 6. Worldview/diversity/holding multiple truths/trauma informed | 3.57 (0.76) |
| 7. Mutual responsibility: Belief in the power of relationship | 3.64 (0.75) |
| 8. Shared risk (e.g., ability to negotiate fear, anger, conflict) | 3.64 (0.63) |
| 9. Moving towards the positive | 3.62 (0.77) |
| 10. Creating community/social change | 3.62 (0.51) |
| 11. Code of Ethics | 3.36 (0.84) |

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For Family Peer Support Specialists, we asked how valuable training would be for the core family peer support competency areas using the following scale:

- 1= Not valuable
- 2= A little valuable
- 3= Quite valuable
- 4= Very valuable

Table 10 shows the results. The average rating for each of the competencies was between quite valuable and very valuable except for “confidentiality and ethics” which averaged between “a little valuable” and “quite valuable.” The highest rated competency for additional training was 3.50 for “coaching for personal change and crisis prevention.”

Table 10: Family Peer Support Specialist Ratings of Value and (Standard Deviation) of Need for Training in Core Competency Areas by Respondent Group

| Competency Areas | Family Peer Specialist |
|---|------------------------|
| 1. Effective use of lived experience | 3.33 (0.96) |
| 2. Listening skills and cultural competence | 3.25 (0.94) |
| 3. Confidentiality and ethics | 2.83 (1.24) |
| 4. Effective assertive written and verbal communication | 3.00 (1.10) |
| 5. Mentoring leadership in others | 3.29 (0.91) |
| 6. Cultural diversity and use of family-driven/youth-guided resiliency/recovery oriented approach to emotional health | 3.42 (0.83) |
| 7. Current issues in child developmental, emotional, behavioral, or mental health | 3.42 (0.78) |
| 8. Parenting for resiliency and wellness | 3.46 (0.72) |
| 9. Coaching for personal change and crisis prevention | 3.50 (0.72) |

Focus Group Results

Focus groups were held for adult peer support specialists, family peer support specialists, and consumers of these two services. In total, 25 adult peer support specialists, 31 family peer support specialists, 57 adult consumers, and 34 family consumers attended the sessions. Major themes that arose from the focus groups included peer support services in general, peer support resources/expansion, coordination of peer support, skill development, trauma informed care, and the peer support certification process. The certification results are presented in a separate report. A caveat should be noted for the focus groups results: the opinions expressed by focus group participants are based on their perceptions. In this process, we make no attempt to verify or refute factual statements. The perceptions themselves are the data for this analysis.

Peer Support Services in General

Overall, adult peer support specialists feel supported in what they do – from agencies, the region and the State. Participants thought Nebraska has made tremendous progress in recent years and this is due to state, regional and agency leadership. Specialists noted that by becoming a peer support specialist, others “may see in you what you have not seen in yourself.” It is a very validating experience. It improves confidence and self-esteem to provide help to others.

Some thought the facilitator circle should have longer meetings to develop direction for peer support in the State and to decide on and implement strategies; it is hard to do this on a one-hour phone call. Some thought the facilitator circle should be expanded and include more individuals.

Adult Peer Support Consumers thought peer support is a wonderful resource. They indicated mutuality is the most important part of peer support and thought peer support specialists provide excellent guidance during periods of crisis.

Some recommendations included having a statewide 24 hour peer-run warm line and having more peer-run drop in centers that can be training grounds for peer support specialists. Some family peer support specialists recommended stronger program evaluation for peer support services. Comments about evaluation include the following:

- There needs to be a better way for peer support specialists to be able to show positive outcomes.
- Surveys are not good data collection instruments. Families hate filling out surveys. They will not fill those out.
- So how does one document and show positive outcomes? There needs to be training directed at this area.

Both adult and family consumers strongly supported peer support services. Family consumers indicated peer support provides both emotional and informational support. They noted parents may feel anger and confusion because of the system and situations they are experiencing; peer support helps guide parents through the system while providing emotional support for their anger and confusion; peer support provides opportunities for families to know and support each other; they coordinate group support events so families can develop resiliency.

Peer Support Resources/Expansion

Many adult peer support specialists and adult consumers thought there are not enough adult peer support specialist positions to meet the demand, and there is not enough funding to support more positions. Some stated the State should advocate for more paid positions. The need for additional peer support services was mentioned as a particular need in rural areas. As

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one adult consumer indicated, "We need to be able to talk to someone who has the same experience – this is priceless and essential for recovery."

There have been talks with Magellan since they were awarded the managed care contract about using Medicaid to expand peer support, but participants were not sure where this was in the process. Participants thought there was a need to expand Medicaid funding, which will also reinforce the legitimacy of peer support services.

Participants indicated funding is a perennial challenge to peer support services in general, particularly to fund training. Previously, there had only been one qualified trainer in one of the rural regions, although now there are two. Trainings were difficult to attend because it involved a lot of travel. Participants thought there should be funding to pay for time off work and travel to attend training.

Some adult peer support specialists in rural areas thought additional resources would help individual's access peer support services. Transportation is a difficult issue in particular because there are few services outside of the major towns. There is a lack of resources available to travel to other communities to address the needs of people who need them. Peer support specialists thought they needed to be able to see people more than one time in order to build strong relationships, but they cannot do that if consumers cannot access services. This idea was also expressed by family peer support specialists: Transportation is a large barrier. Many families may not have cars and need help to attend professional sessions or meetings with case workers. The lack of transportation can be very difficult for families, and if they are unable to attend mandated meetings, it would be viewed as being out of compliance with their plan. The family peer support workers are not able to provide transportation to families any more. This results in a significant access problem and has a direct impact on outcomes for the family.

For example, there was one instance where a 9 month pregnant client had to take a bus in the summer heat to her counseling appointment. She did not have a car. She was unable to walk the last mile from the bus to the counselor's office. Peer support rushed to help her. But if that client had not been able to make her appointment, it would have been considered a lack of compliance on her part.

Some adult consumers indicated they would like support services to be available in the evenings and also the weekends. "Everything shuts down during the weekends and evenings." They attributed this to lack of funding. They would also like the ability to use computers to access the internet. Having more resources would allow them to do more things in the community, which would be good, such as group trips, going out to eat, going to events like fairs, picnics in the park, etc. These are good because it helps one get out and be physically active.

Family peer support specialists also thought there is a need for more funding for additional peer support services. They indicated there are regulatory barriers in funding that impede the

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provision of services. Children with autism and developmental disabilities are currently not covered under family peer support services funded by the State of Nebraska. These populations need to be served by peer support and receive other services as well. Local agencies try to be resourceful to serve families, but direct access to services can be challenging for those families which do not meet specific criteria.

Some family peer support specialists thought there is a tremendous lack of funding in general even to provide services for those who are covered. A preventative approach would be very helpful. If it could be mandated that families receive peer support services at a very early stage in the child welfare system, it would help prevent problems from occurring. For example, family peer support should be introduced at the point when children are removed, or even before they are removed. Because peer support specialists may not be involved early in the process, by the time they are brought to the case, the problems may be much worse than they were originally. When the referral is too late into the process, there may be little that a family peer support specialist can do to help, and they may be perceived as antagonists (which is not the case).

Some family peer support specialists thought additional resources are needed for new smart phones; tablets for documentation would be great. There is a need for internet access as well as resources for family training.

Coordination of Peer Support

Adult peer support specialists thought there was a need for greater communication among peer support specialists, the regions and the State Office of Consumer Affairs (OCA). There should be more communication about upcoming conferences and about continuing education requirements. There should be less of a top down approach to coordination and more of a collaborative relationship between peer support specialists and OCA. Greater efforts should be made to link peer specialists across the State such as through Facebook or other social media, or by having a special forum on the State web page. Peer support specialists would benefit from greater opportunities to connect with each other. Some of the regions have held conferences in which peer support specialists from other regions have attended, and this has been positive. Feedback was very good. The statewide conference is another opportunity to have a more formal process to connect peer support specialists. The statewide conference seems to have grown to include more providers and administrators. While it is good these individuals are becoming more exposed to the consumer movement, there is a loss in the ability of consumers to share and connect with each other.

Some adult peer support specialists thought there is a greater need for networking with others who work in rural communities. It would be great to share what is working and what is not working. The State should strengthen the networking system so peer support specialists can interact with and learn from each other. There seems to be a general lack of communication. There is a realization that the State tries its best. It is a funding issue. There is a need for greater

awareness about available resources. Networking more would allow people to share knowledge about resources.

Relations with Other Providers/Marketing

Some adult peer support specialists thought a major challenge is a general lack of awareness among traditional providers about peer support services. Mental health agencies are sometimes wary of peer support workers because they do not understand what peer support is, and what the benefits are of peer support. This may be because of fear that peer support specialists are under-qualified. A main concern seems to be lack of credentialing. Traditional providers do not seem to understand that the value of peer support comes from the lived experiences of the peer support specialists. There needs to be education of both employers who may potentially hire peer support specialists, as well as to consumers who may benefit from peer support.

Some adult peer support specialists thought more communication is needed between the Office of Consumer Affairs and the facilitator's circle. Both entities could benefit from increased communication and dialogue. Success stories that involve peer support need to be documented and marketed to consumers, providers, and the community in general. This will help get people to understand the importance of peer support, and why and how valuable it is. Consumers need to know peer support services are available in addition to clinical services. There needs to be a marketing effort for peer support services – what the services are, how to access them and what the benefits are.

Family consumers thought it would be a good role for family peer support specialists to facilitate communication between all services including peers support, OJS trackers, advocates, court therapists, and community support workers. Some family peer support specialists and family consumers thought there is a great need for collaboration and communication among agencies that work in human services and the child welfare system. Having more access to families at early stages of adjudication would be helpful to solve problems before they increase. Some family peer support specialists thought there needs to be better coordination among providers that are working with families, so that peer support services can link up with both families and other providers at an earlier stage.

Some family consumers thought there is confusion between family support/family skills building people, and family peer support workers. It is "like a jumbled mess", parents do not know who to call or contact, and when they do, the delay in getting help, may be detrimental to the youth and the family. Some of the family support workers and trackers seem overwhelmed and understaffed. The family workers and peer support workers need to be connected so they can work together better on behalf of the worker. Peer support needs to be plugged in more closely with the social workers and trackers for the benefit of the family. Navigating bureaucracy is particularly hard if a family is new to the area and does not know who to go to

for help. Because of red tape and unfamiliarity with the system, sometimes families believe the only place one can turn to is 911.

Family peer support specialist indicated there should be a greater effort to increase awareness about peer support across all levels. The following reflect the perceptions of participants:

- There is a lack of awareness about the evidentiary base which shows the value of peer support.
- There is a stigma that peer support workers may not be adequately skilled or trained to provide services to families. There is not an awareness of the value of lived experience that peer support workers have.
- Those in control of funding don't seem to be aware that peer support has a large role in preempting problems from occurring. They don't seem to be listening to either families or peer support service workers.
- There have been very positive individual relationships that have developed between peer support workers and family service workers who recognize the value of peer support. Some workers with the State realize that peer support specialists provide great value. Others do not. This may be because of lack of training or exposure to peer support. Typically, the family case workers that value peer support are veterans. There are many examples of good relationships that peer support specialists may have with veteran, more experienced case workers. The newer case workers are the ones that do not seem to understand peer support very well.
- Younger family workers may not understand the everyday challenges that families in need experience. If the family worker is new, 20-something in age, and never had children with special needs, they may not be able to truly empathize and understand what families need. Family peer support specialists can help build trust and mutual understanding between family workers and the families. Peer support specialists who have that lived experience understand how to navigate the system from a position of hardship. If a family-centered, family-driven system is the goal, then family peers should be helping each other.
- There seems to be a lack of checks and balances in the current environment. In theory, there should be team meetings on a regular basis that include families and family peer support workers with other agency representatives. This is true family-centered practice. However, these may simply not occur. There doesn't seem to be consistent accountability when it comes to making sure the families are involved in their own plans of care. Upper level management may not be aware that meetings are not occurring.
- Family peer support specialists and family consumers indicated there seems to be a lack of transparency and consistency when it comes to some child welfare cases. For example, a family may be told that monitored visits to children are a possibility during one meeting, and then there is a lack of follow up at a later point. This lack of transparency can create confusion and frustration for the family. This could be because of a lot of reasons – case workers may be overloaded, it may be because of a lack of training, or it could be because of the personality or style of the individual case worker. This may be exacerbated by the high turnover in case worker personnel. Better

coordination between case workers, peers support specialists and families may help with this.

- The way that referrals to peer support organizations are currently structured, referrals are sometimes not made on the basis of relationships or fit with the strengths or backgrounds of particular peer support organizations or specialists. By adhering to an allocation process that does not consider particular characteristics of an organization or specialist, it decreases the likelihood that a family will be paired with the best organization or specialist. Making sure there is the most appropriate fit for a family with a peer support specialist who has had the same or similar experiences is critically important. Sometimes, case workers are not documenting the information that is needed to appropriately match the family with the right kind of peer support specialist or organization.

Skill Development

Adult peer support specialists thought there is a need for training in suicide and self-harm for peer specialists. People are afraid of these areas in general, how to handle those topics as peer specialists, and ways to have conversations about them, particularly if a life threatening crisis is at hand (talk of self-harm, etc.). Having the ability to network with other peer specialists would be very beneficial. Specialists would be able to learn what other peer support workers are doing in their communities. There is a list of certified peer specialists in Nebraska. In the western part of the State, there are very few certified specialists, and most may know each other. It would be helpful to regularly update the statewide list of peer specialists and provide opportunities for training and networking.

Some adult peer support specialists from rural areas thought it doesn't seem like western Nebraska really exists in the eyes of Lincoln or Omaha. The in-person training rarely comes to the west. There is a need for there to be more in-person trainings in the far west so one doesn't have to spend a day or two driving and then staying overnight somewhere. That is a barrier if peer support specialists have to work other jobs, have a family and balance that with traveling for training. People cannot take time off from work to attend trainings. Another option would be for there to be more funding for training for those in western NE to go east. However, having training locally is the most preferred option.

Adult peer support specialists thought additional topics would be beneficial for training including the following:

- Training on strategies and knowledge of recovery models,
- Communication with professionals,
- Recovery engagement strategies,
- Assertiveness and boundaries as well as neutral relationships,
- Communication and compassion with clients,

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- Self-care training, listening skills, and motivational interviewing

Some adult consumers thought it would be helpful to have training on skills to manage over-helping, such as how to take a step back when things are too intense; additional education and training on understanding medication management, basic medication and side effects such as sleepiness and the effects of medication in general would be helpful.

Some family peer support specialists thought there was a need for additional training. Most of the trainings that occur seem to be designed for larger communities. Additional areas of training for family peer support specialists include the following:

- Needs to be more mental health and chemical dependency courses available for peer support
- Information for working with schools needs to be increased
- Need to know how to share lived experience including effective boundaries, professionalism, and how to work without triggering clients symptoms
- Need training on coaching skills,
- Would like to have information on other states experiences in the rural areas
- Need for cultural diversity in training with Sudanese, Asian, Hispanic, biracial, Native American and American Indian populations
- Training on conflict resolution
- Training on the court system and how it works,
- Training on addictions 101 - home safety signs and symptoms and reporting drug and alcohol problems
- Training on how to share a lived experience appropriately
- Training on coaching
- Training on cultural diversity
- Training on safety assessments and going into homes as well as mandatory reporting guidelines
- Training on how to engage families and how to motivate clients to stay in services, successful discharge strategies
- Training on family dynamics
- Listening skills

Family peer support specialists thought there needs to be an emphasis on building relationships with families, where there may be resistance or suspicion to seeking help. Tribal communities in particular may be wary of services. Because of distance, travel time can be a major challenge to developing strong relationships with families. Tribal communities tend to prefer members of their own culture. For example, peer groups with non-native members may not be attractive to Native Americans. There is a great deal of racial tension in many areas of the State. There is a perspective among some that non-Native homes are not culturally appropriate environments for Native children. There are tribal services or services available on the basis of tribal affiliation that may be available for children or families, but there are Native American families that may not be enrolled with a particular tribe. This is a major barrier for access to services that family

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workers need to be able to understand and navigate. Many new case workers do not understand the nuances and regulations of working with tribes and Native Americans. There is also a lack of communication between tribes and the federal government that cause problems, particularly in regards to the Indian Child Welfare Act. Training on these issues would be very valuable for both case workers and family peer support specialists.

Crisis response and cultural competency are important areas that need improvement according to some participants. There seems to be a lot of turn-over in family and child support staff generally. Having regular trainings in which those staff become familiar with area agencies and practices would be helpful, particularly in how to coordinate with peer support services.

Family peer support specialists thought there is a great need for families to learn how to become and stay resilient, particularly in isolated rural communities where there is a lack of strong social support. Families may receive treatment but upon completion may not maintain healthy lifestyles. Or they may go back to socializing with their same family members or friends who are bad influences, like alcohol/drug users. There are limited opportunities for socializing in a positive way in rural areas. There is a need for peer support training that recognizes and ideally helps to address this gap.

Family peer support specialists thought it would be beneficial for services providers to learn new communication styles and understand the perspectives of families. Being able to effectively work with families is critical, and understanding how the families analyze and perceive the situation is important. Building on the strengths of families is an important strategy, rather than fault finding. Families are experts in their own lives, and professionals need to be able to work towards those strengths and not their dysfunctions. A training based completely on the family's perspective would be very helpful. Learning boundaries is another important training need. There are professionals who would benefit from training in boundaries, as well as in debriefing methods to de-stress from their work.

Family peer support specialists thought other child-serving professionals could also benefit from other types of training and enhanced resources. Some of these ideas are as follows:

- The State needs to provide training to its own workers about how to work with families well. The State's workers and contractors need to be able to communicate and engage with parents better. Training should occur with the supervisory level and case workers to prepare them to engage with parents in more approachable, friendlier ways.
- One issue is that there are very few professional providers in the area. The same providers seem to diagnose patients in the same ways, and there is no way to get a second opinion. It is unclear if the initial diagnose is correct, or if it is more a reflection of the professional's inclination or training. Having more professionals available, so additional evaluations can be done, might correct the perception (right or wrong) that mental health diagnoses are not being done appropriately.
- The State could also help by finishing the database they are working on that lists all the allied organizations that can be called upon for assistance in communities across the

State. There are several efforts ongoing in this area, but there is some overlap. There needs to be a single database that everyone can access, with no duplication.

- The State needs to direct training towards the school system. School personnel may not be properly equipped to address mental and behavioral health issues. In some cases, the schools do not seem to want to work with family peer support specialists. School personnel sometimes are not aware of what the rights of parents are. They are sometimes overwhelmed and could benefit from training in this area.
- There needs to be training directed at operational level staff who work as child and family service case workers about the perspectives of families in the system, and how family peer support specialists can help them. Training needs to be ongoing because there is a high turnover rate among the State's case workers. Such training needs to be institutionalized so there is regular cooperation and feedback between peer support specialists and case workers so there is a true family centered system of care.

Trauma Informed Care.

Adult peer support specialists were generally excited by the direction the State was going with training on trauma informed care. Peer Support Specialists believe they are well equipped to address trauma since a day of IPS is devoted to trauma and they receive other trauma training. There should be more training on vicarious trauma and compassion fatigue. Some thought trauma training should be specific to the role of the peer support specialist. Peer support specialists need to take care of themselves. There should be annual training on this and employers need to know about this so they understand when peer support specialists need time off. There should also be trauma training for service providers so they know the impact on consumers. "Living Life Out Loud" is an excellent pilot program and needs to be expanded across the State.

Family peer support specialists thought additional training on trauma would be useful, particularly on how not to trigger trauma and what to do to de-escalate it. They also thought it would be good to have additional training on trauma screening tools and how to use them to help people with trauma.

Some family peer support specialists thought in general, the child and family service workforce, including even peer support workers, are not adequately equipped to serve those with trauma. Family members can become easily frustrated by the complexity of the system, which aggravates the situation. This can actually exacerbate the trauma individuals have already experienced.

Family peer specialists indicated that almost every family in the child behavioral health system has experienced trauma to some extent. More training in trauma would be helpful. The trauma conference that was conducted in Lincoln was excellent, particularly because there was an emphasis on the fact that obtaining success is possible for those who have experienced

tremendous amounts of trauma. What was also critically important about the training was that it included a segment on the experiences of families navigating the system and interacting with professionals, and what those experiences were like from the families' perspectives. Peer support specialists are the first to be contacted by the families. They help orient families to work successfully in the system. Families tend to have experienced so much trauma, that they can create a lot of problems in "the system". They come in yelling and screaming because they have no where else to go. They are desperate, angry and confused. Peer support works to develop safety plans with families, develop their strengths, provide emotional and informational support, and help them navigate the bureaucracy of child and family services.

Summary and Conclusions

Results of the survey and focus groups provided useful information and reflect the perceptions of consumers. The two trauma scales (Posttraumatic Growth Inventory and the PTSD Symptom Checklist) appear to be valid scales that can be used to identify trauma needs and have the potential for monitoring progress while individuals participate in peer support services. The item added to the PTSD checklist regarding use of alcohol or drugs does not have the psychometric properties to be a useful item in assessment or program evaluation. The Consumer Satisfaction Survey would appear to have marginal utility as an ongoing evaluation tool for peer support. Most items and subscales did not have psychometric properties to provide useful evaluation data. The "Participation in Service Planning" and "Social Connectedness" subscales would appear to offer some small degree of utility.

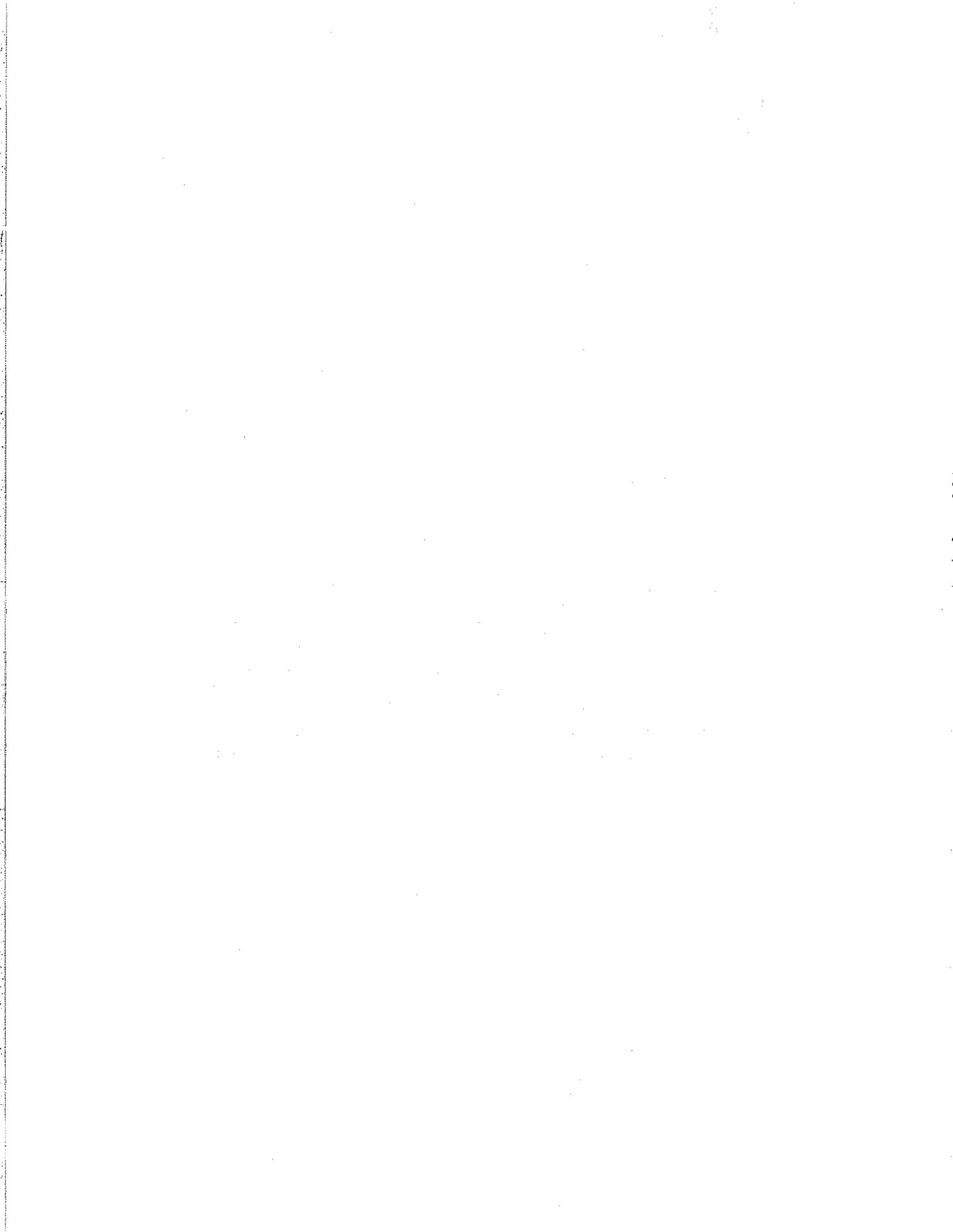
Key findings from the survey about peer support practices include the following:

- Adult and family peer support specialists who took the survey serve primarily populations with mental health challenges or co-occurring disorders, rather than substance abuse disorders.
- Most peer support specialists have five years or less experience.
- A variety of terms are used to describe adult and family peer support, potentially causing confusion about what services may be considered peer support. Given that individuals in focus groups emphasized the need for a strong marketing effort, consistent terms for adult and family peer support specialists may be called for.
- There was a difference in the types of agencies adult and family peer support specialists work for. Adult peer support specialists work for a variety of agencies including mental health centers, provider agencies, behavioral health regions and consumer organizations; family peer support specialists predominantly work for family organizations.
- Both family and adult peer support specialists thought the variety of training they received had been valuable and believed they would benefit from additional training in the core competencies for each group

Key findings from the focus groups include the following:

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- Generally adult and family peer support specialists feel supported in what they do and recognized the tremendous growth and improvements in Nebraska peer support services.
- Consumers made many recommendations for improvement to peer support including the following:
 - It would be beneficial to enhance the Facilitator Circle for adult peer support
 - Stronger program evaluation would improve peer support services
 - More resources are needed to expand peer support throughout the state
 - Additional resource could also enhance access to services (e.g., transportation) and expand the hours of peer support operation to evenings and weekends
 - Greater coordination and communication among adult peer support specialists would be beneficial.
 - Greater coordination and communication between peer support specialists and other types of service providers would be ideal.
 - A comprehensive marketing plan would help inform the public, system partners including referral sources, and potential consumers about the value of peer support services.
 - Focus group results support results from the survey that peer support specialists see the need for additional training in core competency and a variety of other areas. A comprehensive training plan with meaningful input from peer support specialists would be a significant advance. A variety of training mechanisms should be implemented including state and regional conferences with a focus on networking and lessons learned sharing, archived webinars and on-line training that can be accessed at the convenience of peer support specialists, a library of resources that can be accessed through the internet, and trainings that bring together peer support specialists and other behavioral health professionals to learn from each other.
 - Increased training and tools related to trauma informed care is essential to continue the momentum of the Transformation Transfer Initiative (TTI).



G.



Certification of Parent Support Providers

Medicaid Waivers Learning Community Call
February 17, 2013

Certification Commission
NATIONAL FEDERATION OF FAMILIES
FOR THE AUTISM SPECTRUM AND OTHER DISABILITIES
The National Family Leadership Center - National Office

Why National Certification?

- A few states have statewide certification for purposes of billing Medicaid: TN, OR, AZ, KY, MI, ID, OK
- Some state are still either working on state certification or considering it: FL, IA, IN, MH, IL, MA, ME, NY, TX, CO, SC
- The advantages of national certification:
 - No costs to the state to develop or administer
 - Easier to market since it is the same as other states
 - Outcomes can be compared across states

Certification Commission
NATIONAL FEDERATION OF FAMILIES
FOR THE AUTISM SPECTRUM AND OTHER DISABILITIES
The National Family Leadership Center - National Office

Why make it "cross-disability"?

- Children and youth rarely only have one category of challenges: mental health, substance use, intellectual disability, learning disorders, autism spectrum, physical disabilities
- Even when one child or youth could be squeezed into one category, there often is a sibling that does not fit the same category
- Sometimes primary diagnoses need to be reviewed or changed and families need to know their option

Certification Commission
NATIONAL FEDERATION OF FAMILIES
FOR THE AUTISM SPECTRUM AND OTHER DISABILITIES
The National Family Leadership Center - National Office

Parent Support Providers Core Principle and Definition

This is **not** a clinical service.
It is a **peer-to-peer** service.

- ▶ The Parent Support Provider is a **peer** of the parent that is being supported. Their relationship is based on the sharing their own parenting or "lived experience."
- ▶ For purposes of certification in the field of parent support in children's mental health, "parent" in "parent support" means:

A person who is parenting or has parented a child experiencing emotional, behavioral or mental health disorders and can articulate the understanding of their experience with another parent or family member. This person may be a birth parent, adoptive parent, family member standing in for an absent parent or a person chosen by the family or youth to have the role of parent.

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Parent Support Provider Service Definition

- ▶ The focus of the service is on **empowering** parents and caregivers to parent and advocate for their child/youth with emotional, mental or behavioral health related disorders or challenges
- ▶ The scope of the service involves **assisting and supporting** family members to navigate through multiple agencies and human service systems (e.g. basic needs, health, behavioral health, education, social services, etc).
- ▶ It is **strength-based** and established on mutual learning from common lived experience and coaching that:
 - promotes wellness, trust and hope
 - increases communication and informed decision making and self-determination
 - identifies and develops advocacy skills
 - increases access to community resources and the use of formal and natural supports
 - reduces the isolation that family members experience and the stigma of emotional, behavioral and mental health disorders

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FOR THE CHILDREN'S MENTAL HEALTH

Domains of Competency

| | |
|--|--|
| <ul style="list-style-type: none"> • Ethics • Confidentiality • Effecting change • Currency on children's behavioral health treatment and prevention information • IDEA information | <ul style="list-style-type: none"> • Communication • Parenting for resiliency • Advocacy in and across systems • Empowerment • Wellness and natural support |
|--|--|

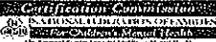
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| Ethics | Confidentiality |
|--|---|
| <ul style="list-style-type: none"> ▶ Cultural and linguistic competency ▶ Peer to peer principles (family-driven, youth-guided, consumer driven) ▶ Compliance with laws and regulations ▶ Duty to do no harm ▶ Responsibility to remain current in the field ▶ Responsibility as a certificant ▶ Principles of non-exploitation | <ul style="list-style-type: none"> ▶ HIPAA, IDEA, 42 CFR ▶ Inter agency protocols (ROI, MOA, MOU) ▶ Understanding conflict of interest ▶ Teaching family members about confidentiality ▶ Child/adult protection, juvenile justice and criminal prosecution related issues ▶ Duty to warn and domestic violence issues |



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 Phone: 202-462-1000 Fax: 202-462-1001

| IDEA and Other Education Information | Currency on Children's Behavioral Health Prevention and Treatment |
|---|---|
| <ul style="list-style-type: none"> ▶ Timelines, procedures and regulations ▶ Resources for parents ▶ Communicating written goals and outcomes ▶ Working with enforceable regulations ▶ Mediation ▶ Pre-teaching effective meeting skills to parents and youth | <ul style="list-style-type: none"> ▶ Diagnoses and assessments ▶ Medication ▶ Treatment – EBP, PBE and other practices ▶ Finding and summarizing research and published literature ▶ Addressing complex health information |



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| Effecting Change | Communication |
|--|--|
| <ul style="list-style-type: none"> ▶ Preparing adults for the decision-making process and behavior change ▶ Supporting opportunities for self-efficacy ▶ Using conflict and discrepancy for decision-making ▶ Finding and using psycho-educational material ▶ Use of support groups | <ul style="list-style-type: none"> ▶ Understanding cultural/linguistic diversity ▶ Using distance communication technology ▶ Translating & assisting adults to communicate emotions ▶ Assisting adults with assertive communication ▶ Mediation techniques ▶ Informed and shared decision making |



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Certification Opportunities

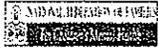
- Certified Parent Support Provider™
 - Entry level
 - Professional level
 - Wraparound specialization
 - Cognitive Disability specialization
- Certified Parent Support Provider Supervisor™
- Certified Youth Support Provider™
- Certified Youth Support Provider Supervisor™

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10000 Wilshire Blvd., Suite 1000, Beverly Hills, CA 90210
The National Family Psychology Institute of National Experts

If you have questions or comments on certification or want to be added to the listserv

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<http://www.ffcmh.org/certification>

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Working Definition of Family-Driven Care



H.

January 2008

Definition of Family-Driven Care

Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- ✓ Choosing culturally and linguistically competent supports, services, and providers;
- ✓ Setting goals;
- ✓ Designing, implementing and evaluating programs;
- ✓ Monitoring outcomes; and
- ✓ Partnering in funding decisions.

Guiding Principles of Family-Driven Care

1. Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility for outcomes.
2. Families and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their families.
3. All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf and may appoint them as substitute decision makers at any time.
4. Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
5. Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.
6. Providers take the initiative to change policy and practice from provider-driven to family-driven.
7. Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families and where family and youth run organizations are funded and sustained.
8. Community attitude change efforts focus on removing barriers and discrimination created by stigma.
9. Communities and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.
10. Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of the diverse populations are appropriately addressed.

F

What does it take to prepare families and support them to be involved in larger issues, more than their own child, community and or system involvement.

Stability

Safety

Support

Value

Education

What do you think it takes to help the providers, to encourage this level of involvement in Family Driven Care.

System commitment to FDC

education

Value

Fidelity / accountability

Family Outreach

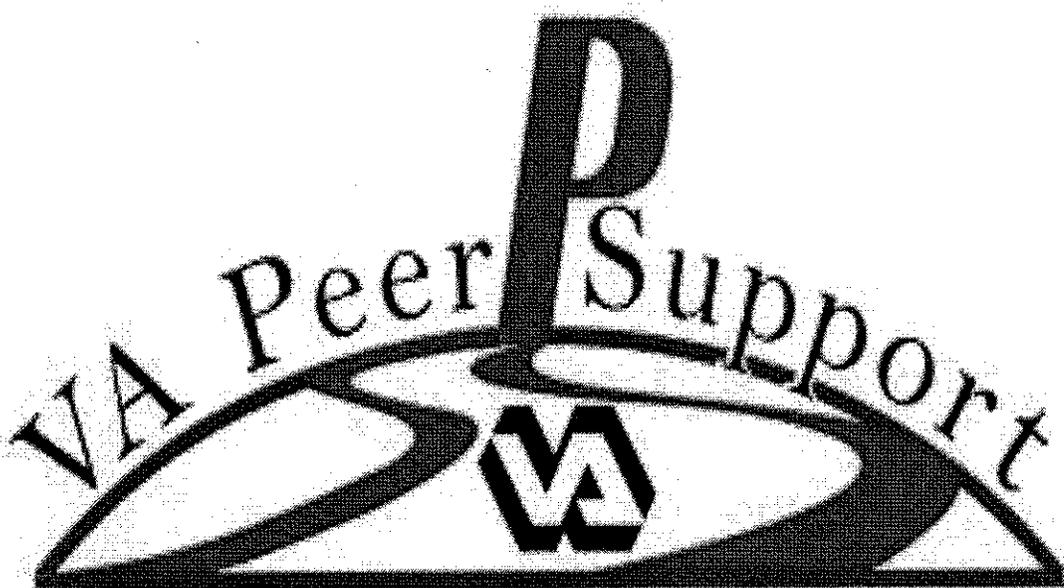
Are there things the system could be doing to advance Family Driven Care? If so what?

Infrastructure

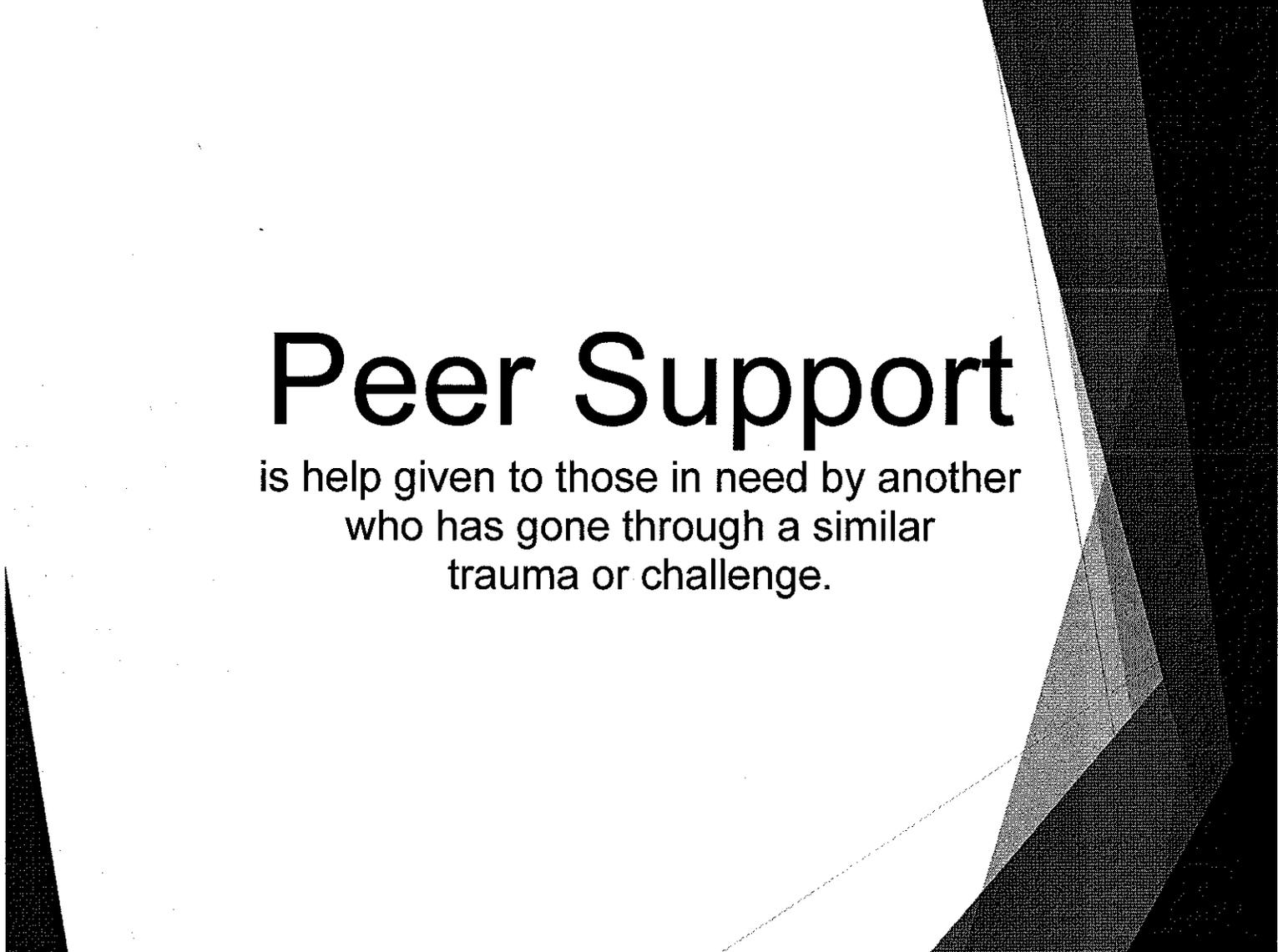
education and awareness

Family Involvement

Oversight and fidelity

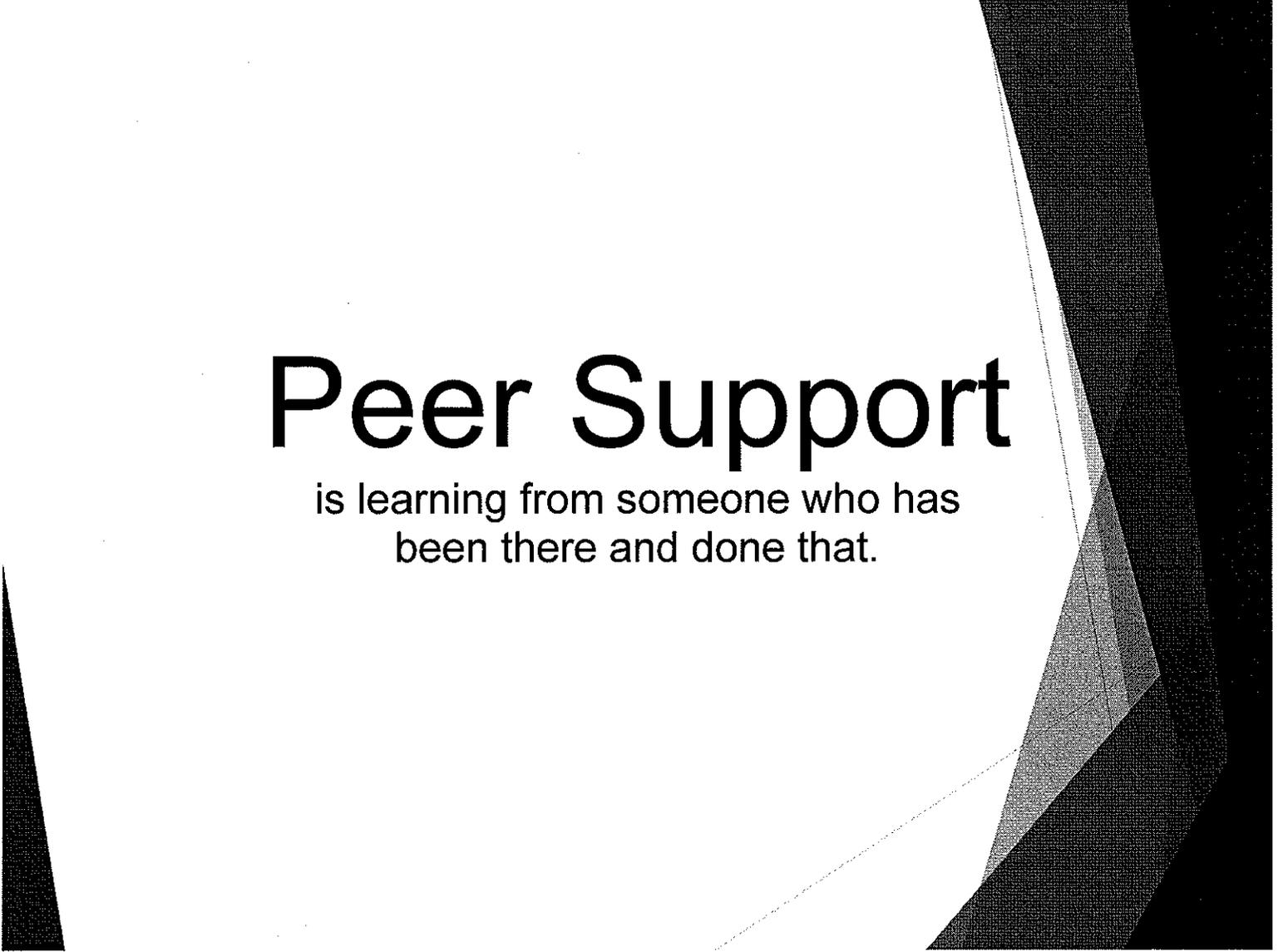


The Road to Recovery



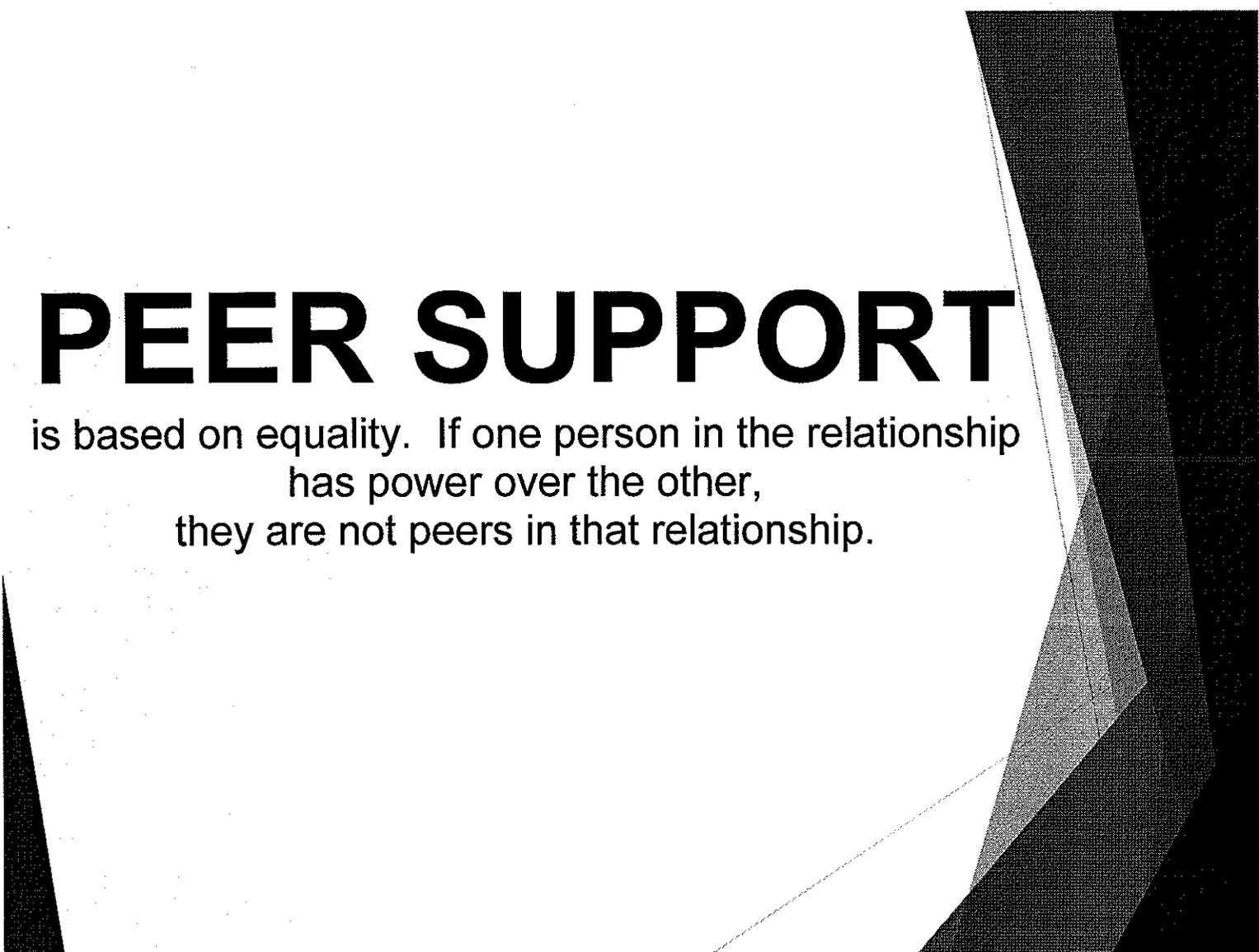
Peer Support

is help given to those in need by another who has gone through a similar trauma or challenge.



Peer Support

is learning from someone who has
been there and done that.



PEER SUPPORT

is based on equality. If one person in the relationship
has power over the other,
they are not peers in that relationship.

Peer support is not about exploring feelings.
Therapists do that.

PEER SUPPORT

is about problem solving.

System Culture Change

SAMHSA's National Consensus Statement on Mental Health Recovery reflects basic consumer/survivor principles.

▶ Evidence of system culture change as a result of consumer/survivor involvement at all levels of mental health system:

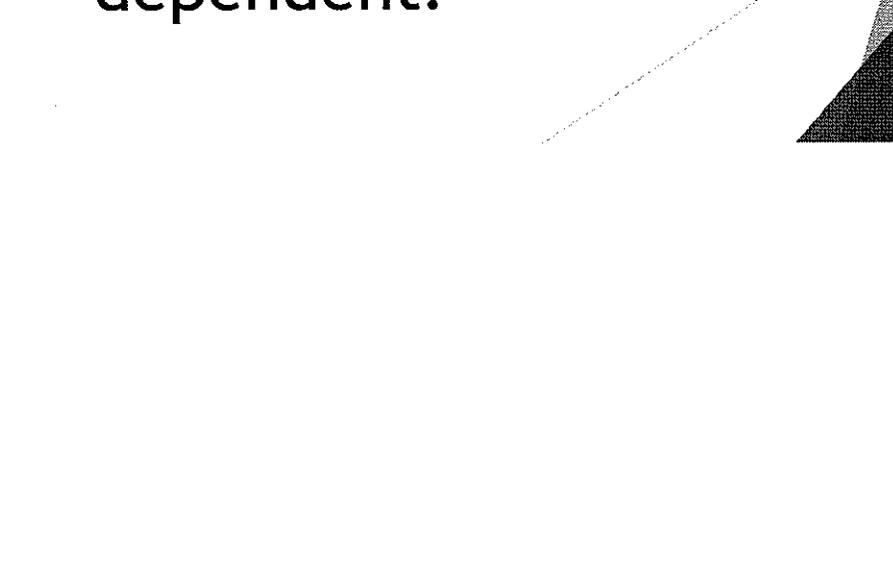
- **Promotion of recovery as a goal**
 - ▶ Consumer/survivor values embedded in Mental Health Services Act, ballot initiative passed into law by CA voters:
 - ▶ Voluntary promotion of self-help/peer-support programs
 - ▶ Involvement of consumers/survivors at all levels of mental health system
 - ▶ Involvement of consumers/survivors as part of and in training of mental health work force

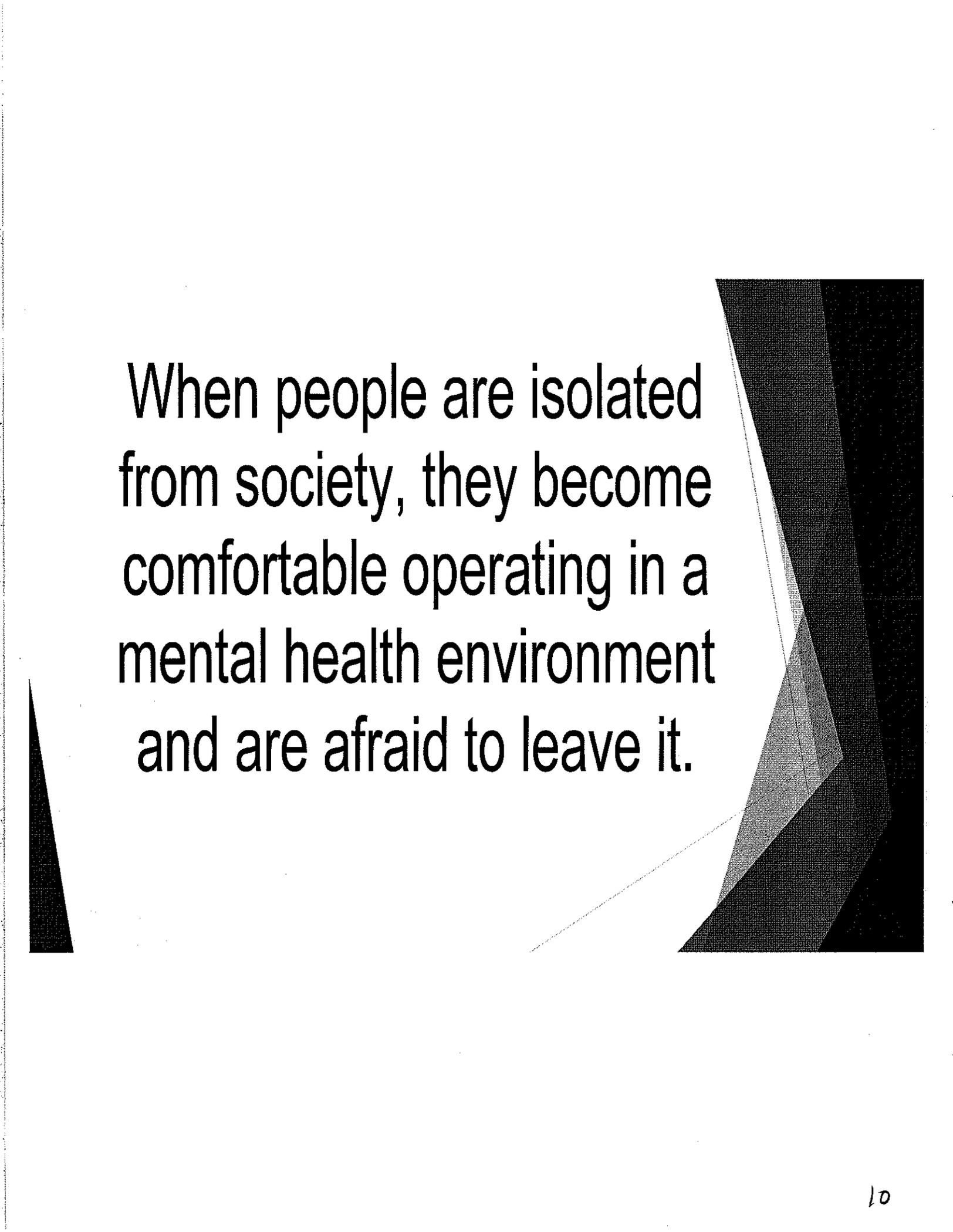
Recovery

involves changing people's
belief systems.

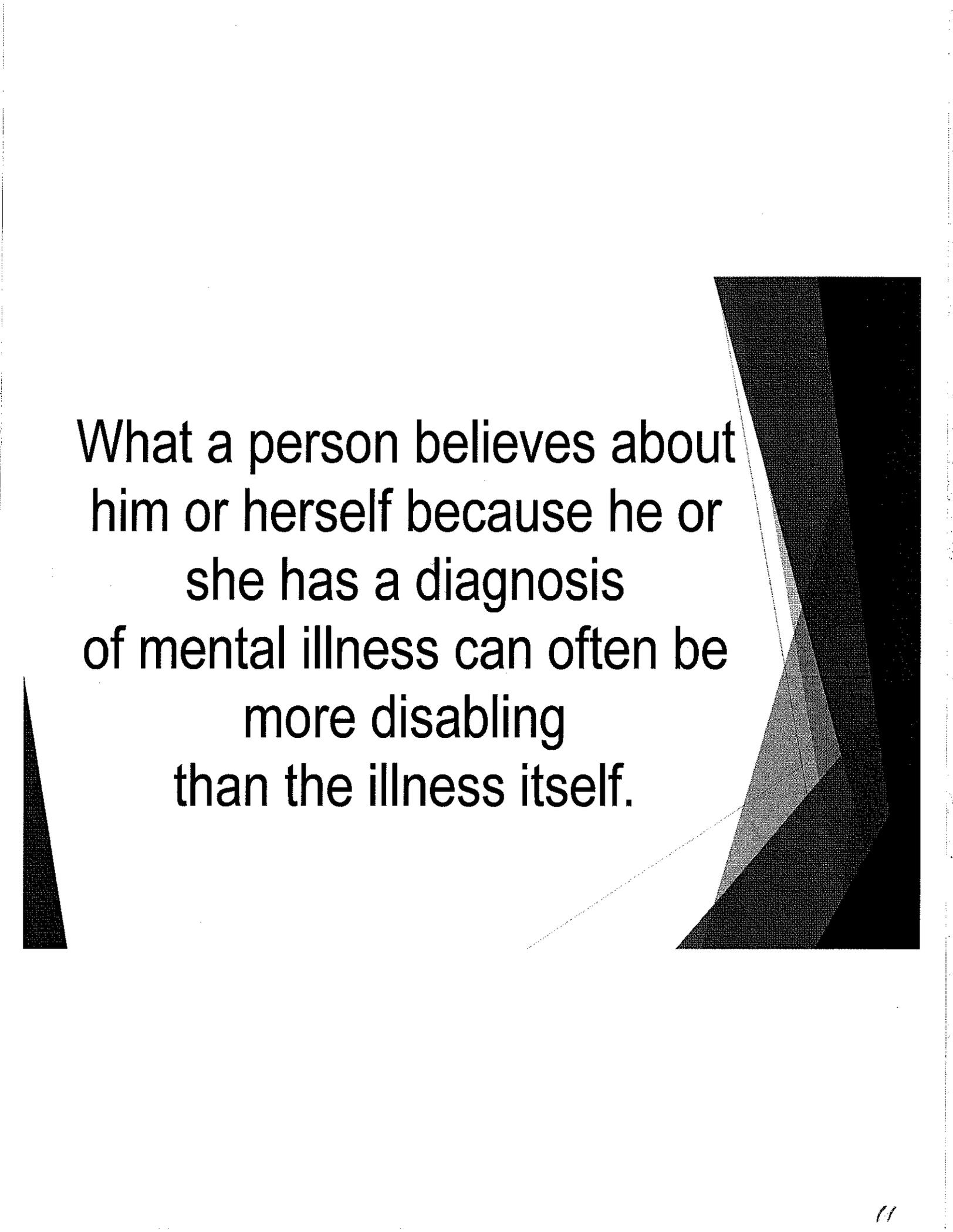
Recovery

is not the absence of symptoms,
but the development of new meaning and purpose
as one grows beyond the catastrophic effects
of mental illness.

- 
- When the focus is only on the illness, people begin to see themselves as disabled.
 - When everything is done for another person, that person quickly becomes dependent.

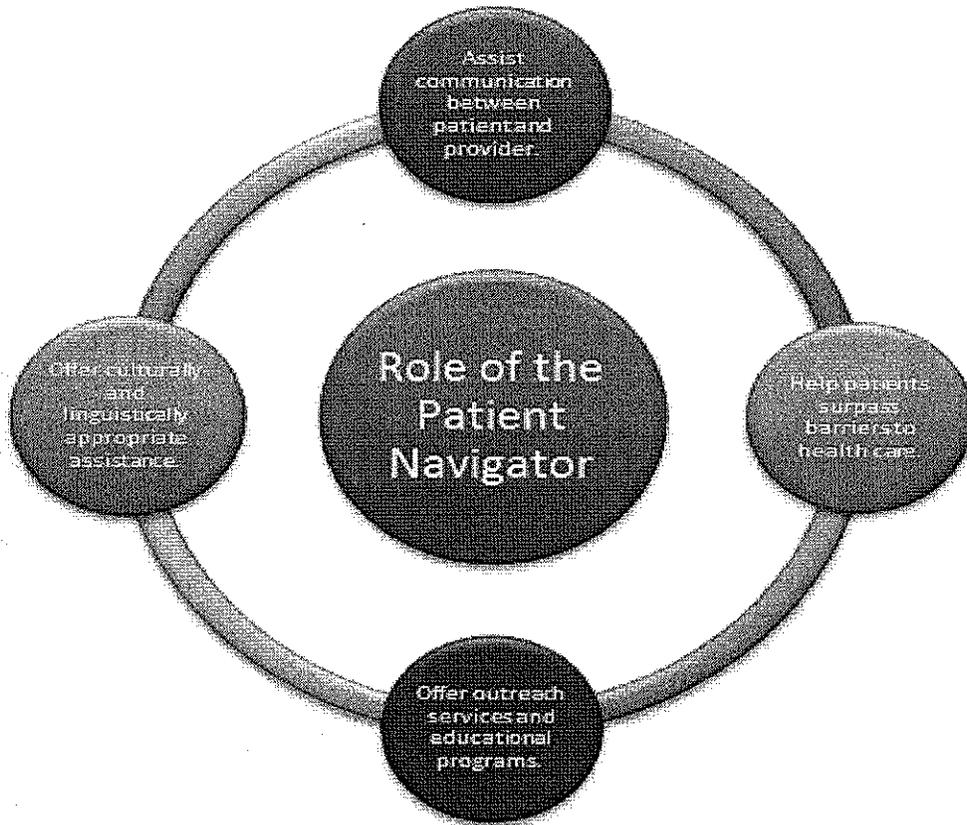
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When people are isolated from society, they become comfortable operating in a mental health environment and are afraid to leave it.

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What a person believes about
him or herself because he or
she has a diagnosis
of mental illness can often be
more disabling
than the illness itself.

AFFORDABLE HEALTH CARE
FOR AMERICA ACT





- - coping effectively with life and creating satisfying relationships
- - satisfaction with current and future financial obligations
- - developing a sense of connection, belonging, and a well-developed support system
- - expanding our sense of purpose and meaning in life
- - personal satisfaction and enrichment derived from one's work
- - recognizing one's need for physical activity, diet, sleep, and nutrition
- - recognizing creative abilities and finding ways to expand knowledge and skills
- - good health by occupying pleasant, stimulating environments that support well-

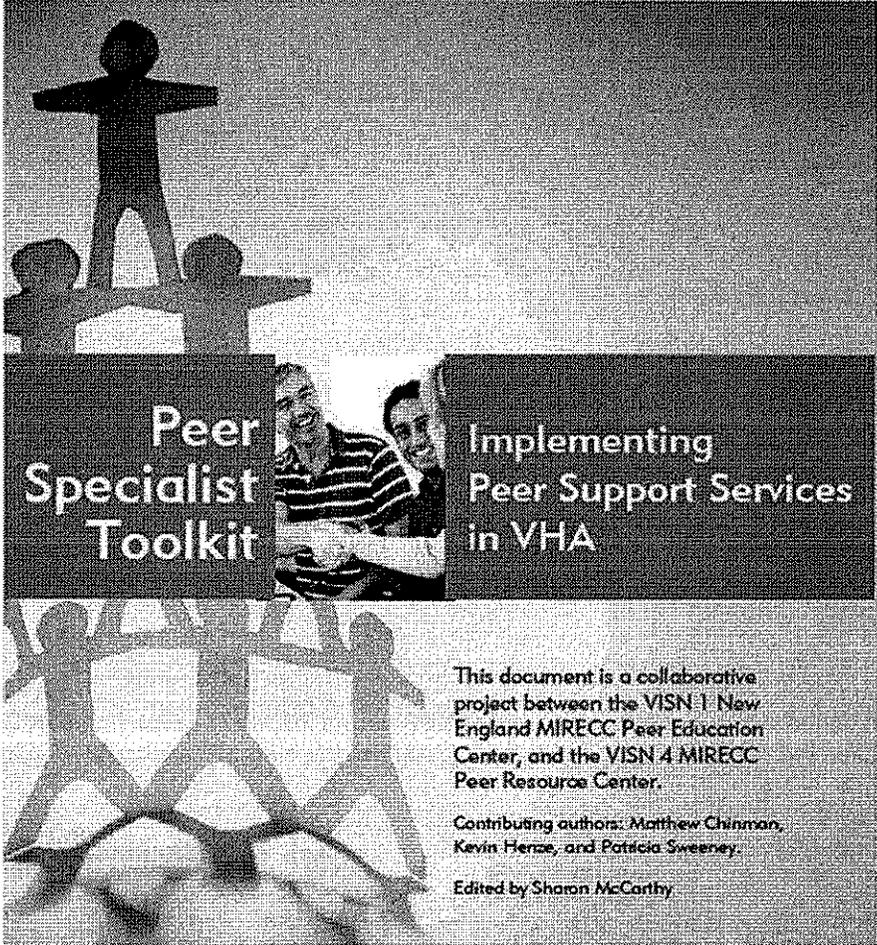
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What does the research say about peer support?

Peer Support Research Outcomes

- In the past, studies that are more descriptive showed that peer support providers were often better able to:
 - Empathize
 - Access social services
 - Respond to clients' strengths and desires
 - Be tolerant, flexible, patient, and persistent
- Peer support was recognized by Centers for Medicare and Medicaid Services as an evidence-based practice in 2007
- Over 20 states have Medicaid reimbursement for peer support services.
- The first VA study, called the PEER Study, looked at Peer Support Technicians and found PSTs influenced Veterans' involvement in their own care and increased their social relationships (Chinman et al., under review).
- There are 14 studies of peer support providers in non-VA clinical settings. Eight of these studies showed some positive benefit to clients of peer support, including:

| BENEFIT | STUDY |
|---|---|
| Less inpatient use | Clarke et al., 2000; Klein et al., 1998; Min et al., 2007; Landers & Zhou, 2009 |
| More time and engagement with the community | Clarke et al., 2000; Min et al., 2007 |
| Better treatment engagement | Craig et al., 2004; Sells et al., 2006; Felton et al., 1995 |
| Greater satisfaction with life | Felton et al., 1995 |
| Greater quality of life | Klein et al., 1998 |
| Greater hopefulness | Cook et al., 2010 |
| Better social functioning | Klein et al., 1998 |
| Fewer problems and needs | Craig et al., 2004; Felton et al., 1995 |

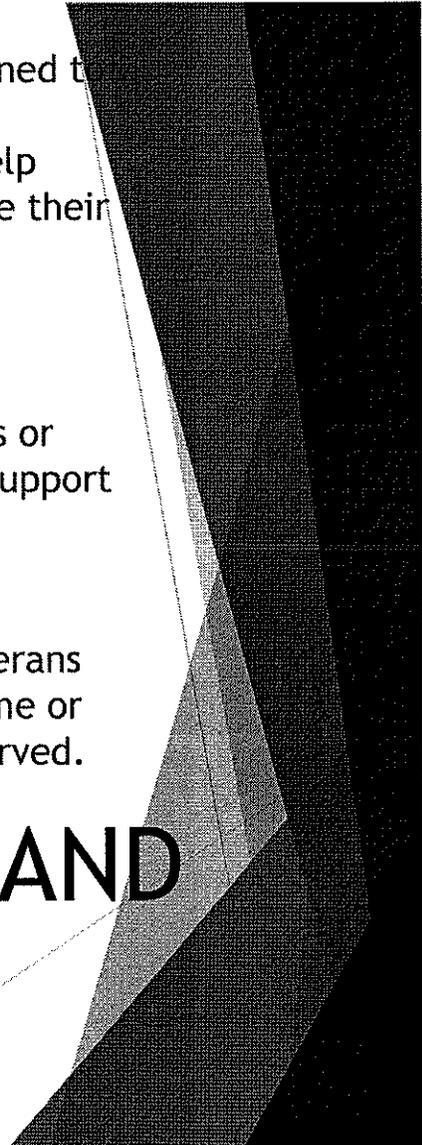


VA | Defining
HEALTH | **EXCELLENCE**
CARE | in the 21st Century



International Association of Peer Supporters (iNAPS)



- 
- a. **Mission.** Peer support services in VA are specifically designed to offer hope for recovery and role models for successful management of mental illness. Peer Support Providers help Veterans develop skills to manage their recovery, improve their quality of life, support their personal goals, and achieve independence from institutional settings.
 - b. **Vision.** All Veterans pursuing recovery from mental illness or substance use disorders in VHA will have access to peer support services.
 - c. **Goal.** To provide Peer Support Services to all eligible Veterans with SMI delivered by individuals recovering from the same or similar types of mental illness as the individuals being served.

VHA MISSION, VISION, AND GOAL

VHA HANDBOOK 1163.051 PSYCHOSOCIAL REHABILITATION AND RECOVERY SERVICES PEER SUPPORT

All Veterans with SMI must have access to Peer Support Services, either on-site or within the community.

Peer Support Providers

- (1) Demonstrate skills for managing recovery acquired through their lived experiences with mental illness and/or substance abuse and as consumers of mental health services.
- (2) Instill hope by providing opportunities for Veteran consumers to observe others in recovery who are not limited to a perpetual sick role.
- (3) Educate consumers by role modeling successful management of mental illness symptoms and the ability to interact successfully within their environment.
- (4) Provide recovery-oriented services that do not duplicate mental health clinical treatments provided by other staff but provide value-added services by individuals who have experienced success with their own recovery and are further along in the process than the Veterans being served.
- (5) Teach Veteran consumers self-advocacy skills to obtain needed resources and eliminate stigma as a barrier to acquiring necessary goods and services.

Referrals for Peer Support

- Housing
- Community Supports
- Lack of family or friends
- Multiple hospitalizations
- Poor social skills
- Low self-esteem
- Boredom
- Multiple “crisis” presentations
- Lack of hope
- Suicidal Ideation
- Chronic unemployment related to MH issues
- Lack of purpose and goals
- Stigmatized
- Alone, lonely or isolated

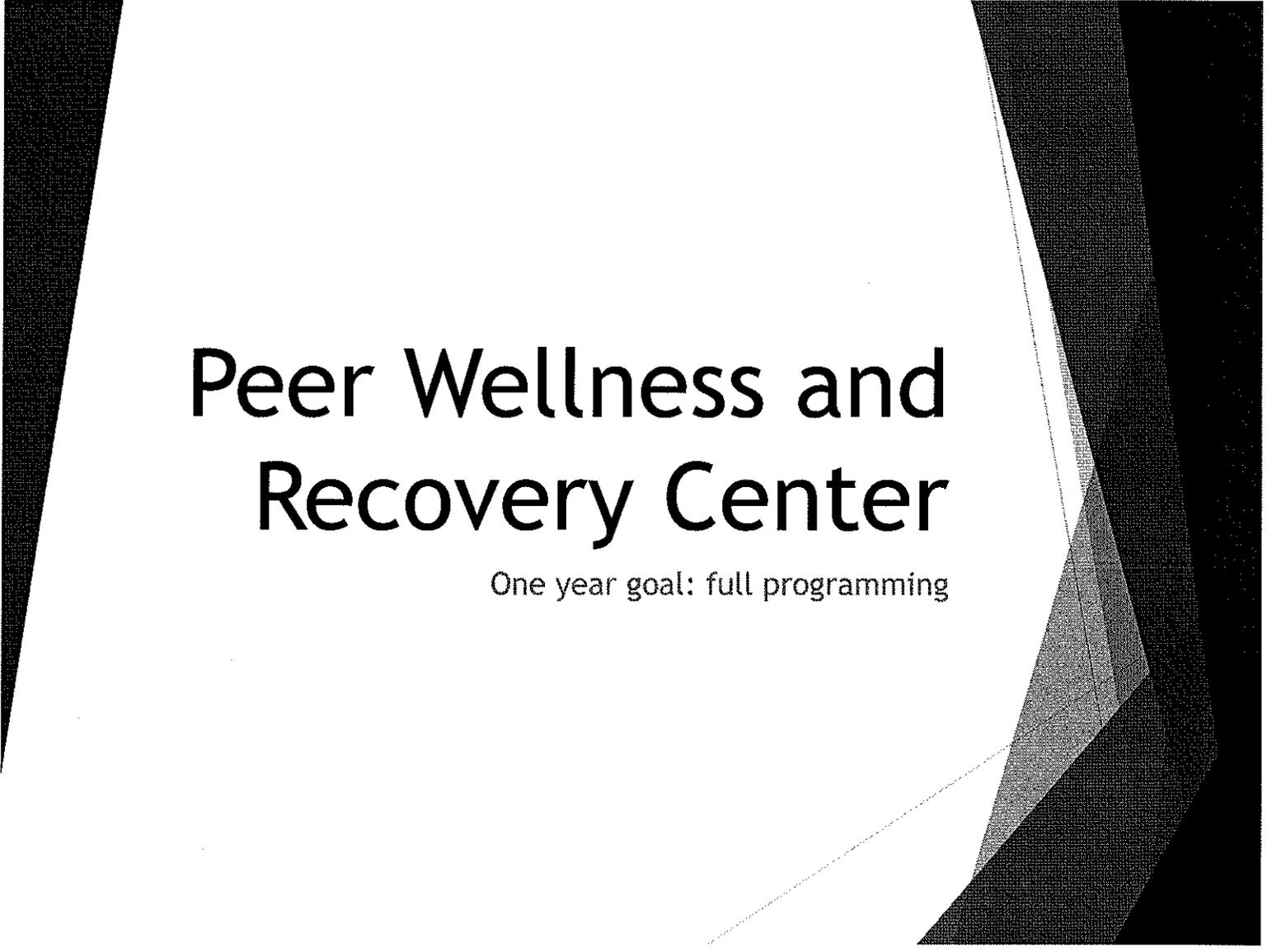
Lincoln Mental Health Clinic Goals

Providers

- ▶ Select role models in recovery from your program
- ▶ Refer to peer support to assist in you in your program
- ▶ Co-sign and oversee groups and referrals

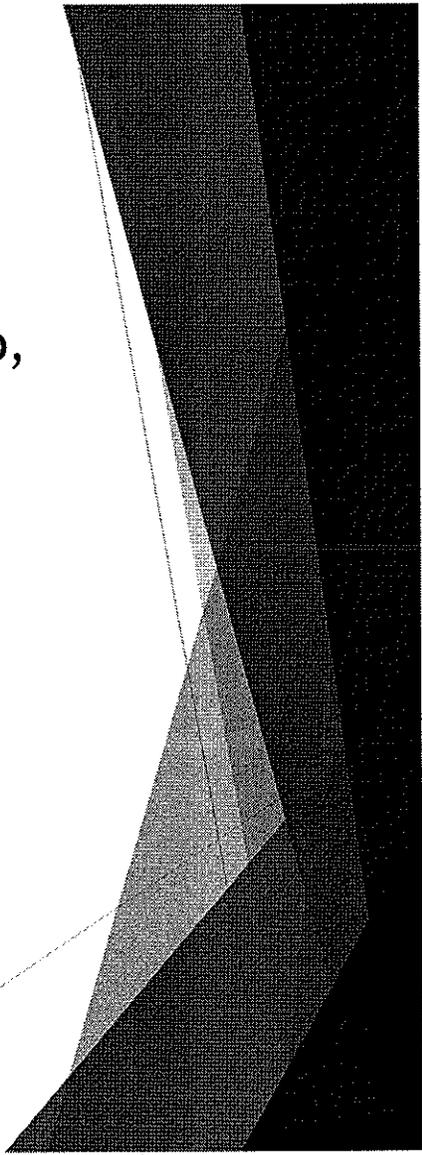
Peer Specialists

- ▶ Training
- ▶ Peer supervision
- ▶ Credentialing



Peer Wellness and Recovery Center

One year goal: full programming

- 
- ❖ The 4 Tasks (Connection, Worldview, Mutuality, and Moving Towards)
 - ❖ The 3 Principles (From Helping to Learning, From Individual to Relationship, From Fear to Hope)
 - ❖ Listening differently and with intention
 - ❖ Understanding trauma worldview and trauma re-enactment
 - ❖ Rethinking old roles and ways of relating
 - ❖ Working towards shared responsibility
 - ❖ Examining power and privilege
 - ❖ Negotiating boundaries and limits
 - ❖ Creating a vision
 - ❖ Navigating challenging scenarios
 - ❖ Using co-reflection to maintain values

VA Volunteer Peer Support:

- Attend volunteer orientation
- Fingerprints
- May have computer access
- Wear name tags
- May be wearing a uniform polo in the near future

Questions?

