

Office of Consumer Affairs

People's Council

DRAFT Agenda

Region V 1645 N Street Lincoln, Nebraska 68508

First Floor Conference Room #1

August 5, 2014

9:00 AM – 3:00 PM

A-Handout

Judie Morehouse	Call To Order	9:00 am – 9:10 am
Carol/ Cynthia	Peer Support Implementation Plan	9:10 am-9:40 am
Break		9:40 am -9:50 am
Carol/Cynthia	Consumer and Family Involvement White Paper	9:50 am-10:50 am
Break		10:50 am-11:00 am
All	Consumer Involvement Discussion	11:00 am -11:30 am
Carol	Contracts and Budget-	11:30 am-12:00 pm
Lunch		12:00 pm-1:00 pm
Carol	MH First Aid	1:00 pm-1:30 pm
Carol	Stages of Change and Smoking	1:30 pm -2:00 pm
Break		2:00 pm -2:10 pm
Joel	Veterans and Peer Support in Nebraska	2:10 pm 2:50 pm
Judie Moorehouse	Adjourn	2:50 pm-3:00 pm

If you have any questions and would like more information, please feel free to contact:

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Nebraska Division of Behavioral Health
OCA People's Council Meeting
August 5, 2014 9:00 am -3:00pm
Region V Large Conference Room
1645 N Street Lincoln, Ne

B-Handout

DRAFT Meeting Minutes

I. Call to order and roll call

Judie Moorehouse

Chairperson, Judie Moorehouse called the meeting to order at 9:17 am on August 5, 2014. Roll call was conducted and quorum determined.

Council members present: Nancy Rippen, Mary Thunker, Jennifer Ihle, Judie Moorehouse, Tammy Fiala, Lisa Casullo, Jonathan Koley, Phyllis Mc Caul, Ryan Leiting, Ryan Kaufman, and Scott Loder

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

II. Housekeeping and summary of agenda

Judie Moorehouse

Judie asked for approval of the agenda with any added or removed changes; a motioned to approve the agenda was made by Mary Thunker and seconded by Lisa Casullo. The motion was approved by unanimous vote.

Handout A: Agenda No changes were made to the draft agenda

Handout B: Past minutes for August 5, 2014

Handout C: Cynthia Harris handed out Draft Peer Support Implementation Plan- Office of Consumer Affairs

Handout D: Cynthia Harris handed out Draft Consumer and Family Involvement White Paper in Nebraska

Handout E: Kim Carpenter handed out Trauma-Informed Care Peer Support

Handout F: Carol Coussons de Reyes handed out Proposed OCA Budget for fiscal Year 2015

Handout G: Carol Coussons de Reyes handed out OCA Contracts

Handout H: Carol Coussons de Reyes handed out Mental Health First Aid

Handout I: Carol Coussons De Reyes handed out How do I get through the rough spots after I stop smoking?

Handout J: Joel Schneider handed out Understanding Peer support Services in Veterans Health Administration (VHA)

Handout K: Joel Schneider handed out How do you talk to a veteran? TALK TO ME,

III. Approval of minutes

Judie Moorehouse

A motion to approve the minutes for May 6, 2014 was made by Mary Thunker and was seconded by Jennifer Ihle. With the corrections to the minutes on the name Amy Beacon to be removed and add BHECN. Adding the correct name to Jonathan Koley. The motion was approved by unanimous vote.

IV. Public comment

No Public Comments

There was no public comment.

V. Peer Support Implementation Plan

Cynthia Harris

Cynthia handed out **Handout C**; Draft Peer Support Implementation Plan – Office of Consumer Affairs Discussion by the members on several questions towards the peer support service and credentialing implementation plan. Lisa Casullo; A. Credentialing; asked about (a). Research of Trauma and Compassion Fatigue found in adults and family peer support workforce and action taken: Jonathan Koley – reviewed ii: Recommendations for Peer Support Credentialing Process January 2014? Jennifer Ihle- commented on training new Facilitators? There are 19 Facilitators and it gets pretty expensive to do the trainings, and not all of the 19 are active. Certification through formal regulatory process comments made: Recertification facilitators staying in tune, improve evaluations, talk about initiatives, and will meet facilitators training refresher and some recommendations **not all are active**.

VI. Consumer and Family Involvement White Paper

Cynthia Harris

Cynthia Harris handed out DRAFT Consumer and Family Involvement in Nebraska. Topics for discussion were on Executive Summary, Nebraska Consumer and Family Movement History, Discussion of Consumer and Family Roles, Strategies for Optimizing and Family Involvement at Every Level, Recommendations and Definitions. Comments on the section history was made that perhaps it should reflect the history of involvement versus the history of the system. Further discussion on how other region specialists could voice other events that happened in Consumer and Family Movement's History and at other large advocating events. Phyllis McCaul said there used to be CAT Teams consumer liaisons voiced on regions. There is a lot of history to be captured. Lisa Casullo commented on resiliency to talk about how people became Advocates about recovery in individual things and experiences on how to do things differently, and on how people changed and touched each other was not focused on. Phyllis McCaul commented on where the legislation is now and the Mental Health Association. Judie Moorehouse recommended that more time was needed to review missing pieces on System of Care this would take time to read and come back to. Judie suggested to form a sub-committee to hold conference calls and report back. The sub-committee volunteers were Judie Moorehouse, Lisa Casullo, Mary Thunker, Jonathan Koley, Ryan Leiting, and Jenifer Ihle. Lisa Casullo commented on Recommendation for Providers – to focus on certain parts and break it down form a sub-committee from regions. Lisa Casullo suggested peer support training for providers will help them understand what Peer Supporters can do. Carol mentioned the website on Trauma and Peer Support is available (www.dhhs.ne.gov/trauma). Carol mentioned the 2 hour OCA webinar 2010 on Recovery and Resiliency. Carol mentioned that the DRAFT version of the Consumer and Family Involvement Whitepaper is better suited to a subcommittee due to the amount of time involved. The OCA also intends to add System of Care information and recommendations that evolve from discussion around the state on the paper. The white paper will continue to evolve and will not be a static document.

VII. Consumer Involvement Discussion

Kim Carpenter

Kim Carpenter handed out Trauma – Informed Care peer support and compassion Fatigue/ Vicarious Trauma. Opened up her presentation by giving us three educational training topics on Care Support Training, How to Train the Trainer, and on Compassion Peer Support. She began by asking what is most useful and meaningful to people in the developmental of vicarious and trauma 101 education?

VIII. Contracts and Budgets

Carol Coussons de Reyes

Carol handed out two handouts on Proposed OCA Budget for Fiscal Year 2015 and OCA Contracts. The handouts were reviewed by Carol with the group. The group invited Karen

Harker to come to the meeting to further discuss the DHHS budget. The group also asked to hear more about our contract with Partners in Recovery.

IX. Mental Health First Aid

Carol Coussons de Reyes

Carol handed out Handout on Mental Health First Aid: Research and Evidence Overview. The handout was reviewed by Carol. The group discussed the recent training offered to Instructors from BHECN. Overview Ryan said the training was Peer Support training. Tammy commented on stigma about high school experiences and that the public needs information aside from what they get in the media. Joel commented that getting it out to the community fast. Joel also said to remember some of the stigma on mental health crisis and knowing what to do for suicide can be very good. Carol supports the skills of Mental Health First Aid may be more powerful when delivered by a peer with lived experience with a behavioral health condition. Carol commented on taking the course for her was a very professional course.

X. Stages of Change and Smoking

Carol Coussons de Reyes

Carol Coussons de Reyes shared handouts on: How do I get through the rough spots after I stop smoking? QuitNOW.negov website, or call Nebraska Tobacco Quitline: 1-800-QUIT-NOW. How to Cope with Withdrawals Symptoms; Medications; Other ways to stay active; Stages of Change –Shirley Deethardt showed some scenarios in the handouts also Words of Encouragement; What about Slips and Relapse? When smokers quit-what are the benefits overtime? Discussion was made on how these handouts were used to support an upcoming webinar that will be released in September for National Wellness Week.

XI. Veterans and Peer Support in Nebraska

Joel Schneider and Ryan Kaufman

Joel handed out handouts on Understanding Peer Support Services in Veterans Health Administrative (VHA). Joel and Ryan both presented and showed a video on the experience of Post-Traumatic Stress and Peer Support. Additionally, Joel shared a presentation on How do you talk to a veteran? TALK to ME. Joel and Ryan shared good questions and questions you might want to avoid –Use of common sense- Sometimes it’s hard. Joel and Ryan both gave a very powerful presentation on what a Veteran is and what they have gone through. Thank you both for having served our country and for your peer support throughout the State.

XII. Meeting was adjourned

Judie Moorehouse

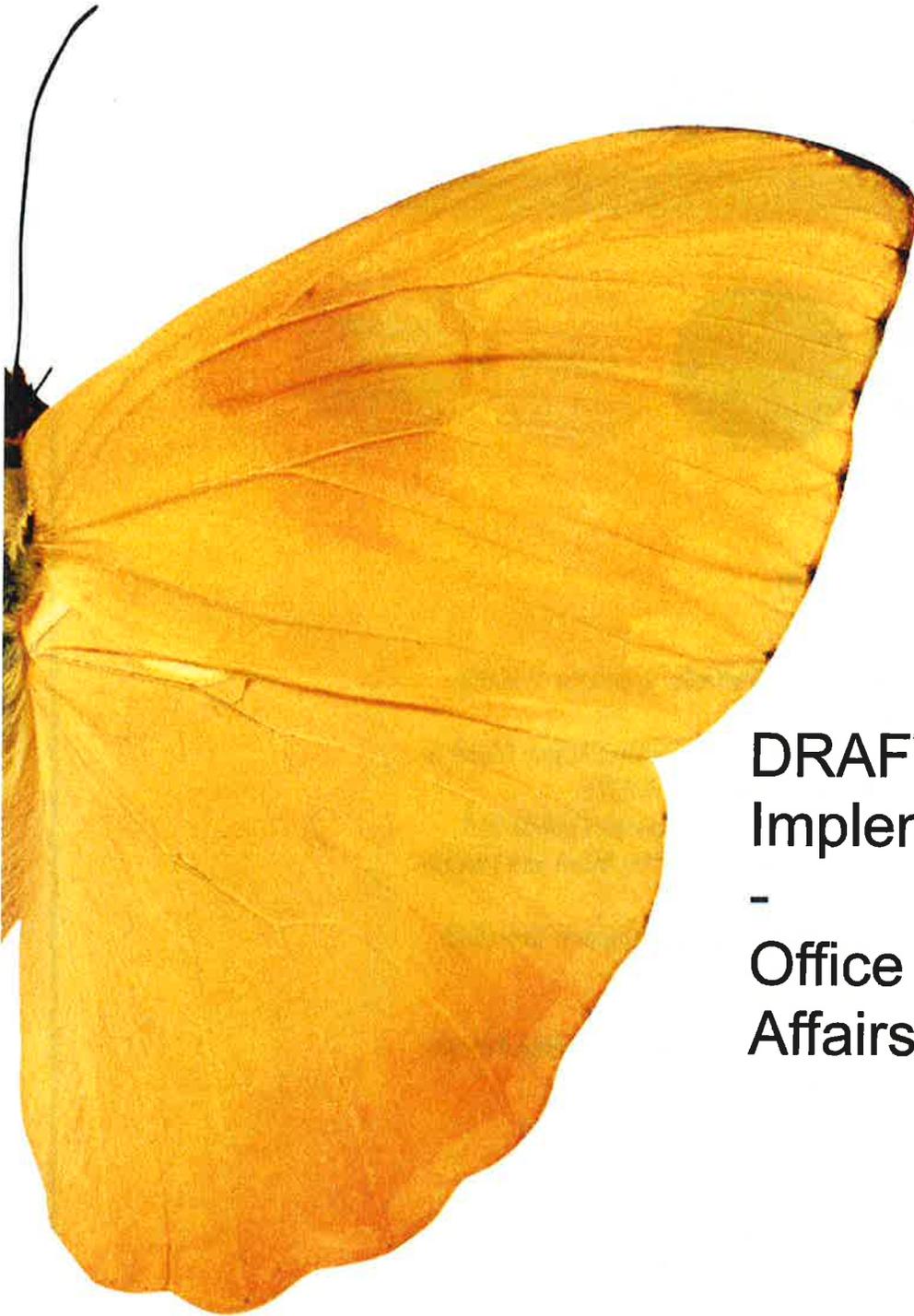
Motion was made to adjourn meeting by Julie Moorehouse; Adjourned by Mary Thunker and seconded by Lisa Casullo. Meeting was adjourned at 3:20 pm August 5, 2014.

Next Meeting is scheduled for November 4, 2014 @ 9:00am – 3:00 pm @
Region V 1645“N” Street Lincoln , Ne 68508

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.

8/5/2014 Meeting Minutes

C Handout



**DRAFT Peer Support
Implementation Plan
-
Office of Consumer
Affairs**

By

Carol Coussons de Reyes
Office of Consumer Affairs
Division of Behavioral Health,
DHHS Nebraska



PEER SUPPORT SERVICE AND CREDENTIALING IMPLEMENTATION PLAN

Study
&
Survey



Phase I: (June 2013 to December 2014)

A. Credentialing

- i. Study of Peer Support and Wellness Specialist Training Conducted in 2013.
 - a. Research of Trauma and Compassion Fatigue found in adult and family peer support workforce.

Action: Two trainings in Compassion Fatigue and Trauma 101 are being conducted for Adult and Family Peer Workforce.

Action: Trauma webpage for Peer Support launched: www.dhhs.ne.gov/trauma
- ii. Recommendations for Peer Support Credentialing Process Created in January of 2014
Recommendations include the following:
 - 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
 - Establish recertification process
 - Certification revocation process
 - Co-supervision and supervision processes
 - Evaluation and Continuous Quality Improvement
 - 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

Action:

- A. Credentialing Workgroup was formed
- B. WRAP recertification course funded
- C. New WRAP trainings are in planning
- D. Resources to the OCA increased for FY15
- E. Workshop on Stages of Change held for Peer Support at Statewide Conference

B. Peer Support Service

- i. Peer Support Survey of Providers in May of 2014 and findings included the following barriers and incentives were important to address for providers in growing peer support in Nebraska:
 - a. Barriers:
 - 69% Lack of awareness of how to **integrate** peer specialists
 - 56% Non-availability of **resources** to hire peer specialists
 - 49% Limited **availability** of training and ongoing education for peer specialists
 - 45% Limited availability of **resources** for program evaluation/quality improvement activities for peer specialists
 - 36% Lack of **capacity** to implement evidence based peer support programs
 - 33% Limited **availability** of certified/sufficiently trained peer support specialists.
 - b. Incentives to Benefit Capacity:
 - 74% Awareness **education** on how to integrate peer support services



- 68% **Resources** to ensure employment of peer support services
- 64% **Capacity** for providing resources to implement evidence based peer support programs
- 58% **Resources** to ensure program evaluation/quality improvement activities for peer support specialists
- 50% Increased **availability** of certified/sufficiently trained peer support specialists
- 43% Proving **resources** for clinical consultation for peer support specialists

ACTIONS:

- A. Adult Peer Support 101 Drafted
- B. 2 Peer Support Trainings per Year Conducted
- C. Overview of Adult Peer Support Drafted
- D. Workgroup Being Generated

Phase II: (March 2014 to August 2015)

A. Credentialing

- i. Credentialing Workgroup formed to inform the Division in March of 2014 to assist processing objectives, like defining the Scope of Practice and Core Functions of the Adult or Family Nebraska Certified Peer Support Specialist. This workgroup will continue until December of 2014.

ACTIONS:

Completed:

- A. Scope of Practice

Tentative Draft:

- B. Core Competencies for All Peer Specialists
- C. Number of hours for knowledge achievement.
- D. A. Supervised practicum experience
- E. Application requirements
- F. Test type
- G. Certification renewal criteria
- H. Number of representatives required for certification advisory board.



To be Determined:

- A. Specific competencies to be created for Youth, Family, and Adult Peer Support
- B. Creation of a grandfathering clause
- C. Code of Ethics
- D. Naming of Credential
- E. Defining practicum
- F. Defining any provisional supervision

B. Peer Support Service

Gather information through Study and Feedback

- i. Survey existing Adult and Family Peer Support Workforce updating the 2012 study information on Employment
- ii. Generate a Workgroup to give recommendations to DRAFT Regulations

Phase III: (August 2015 to December 2015)

A. Credentialing

Tour of the State with Workgroup Recommendations & DRAFT Regulations

- i. Categorize feedback and generate a report to inform final draft of regulations.

B. Peer Support Service

Tour the State with Workgroup Recommendations & DRAFT Regulations

- i. Categorize feedback and generate a report to inform final draft of regulations.

Phase IV: (December 2015 to June 2016)

A. Credentialing

Final Draft Regulations for 206 Regulations and Continuous Quality Improvement Implemented

- i. DRAFT expedited to the Attorney General's Office
- ii. Consumer, Youth, and Family data team formed

B. Peer Support Service



Final Draft Regulations for 206 Regulations and Continuous
Quality Improvement Implemented

- i. DRAFT expedited to the Attorney General's Office
- ii. Consumer, Youth, and Family data team formed

DRAFT:

Consumer and Family Involvement in Nebraska

- 1 EXECUTIVE SUMMARY
 - 2 NEBRASKA CONSUMER AND FAMILY MOVEMENT HISTORY
 - 3 DISCUSSION OF CONSUMER AND FAMILY MEMBER ROLES
 - A) IN OUR OWN LIVES
 - B) IN ADVOCACY & POLICY
 - C) IN PROVIDING SUPPORT (INFORMAL PEER SUPPORT)
 - D) AS A PEER SPECIALIST (FORMAL PEER SUPPORT)
 - 4 STRATEGIES FOR OPTIMIZING CONSUMER AND FAMILY INVOLVEMENT AT EVERY LEVEL
 - 5 RECOMMENDATIONS
 - A) INDIVIDUAL
 - B) FAMILY
 - C) PROVIDER
 - D) POLICY MAKERS
 - 6 DEFINITIONS
-

1. Executive Summary

Of all the resources Nebraska holds, the State of Nebraska's greatest resource are the people. Together we make Nebraska a great state to live in. There are many great people in Nebraska that live lives of resiliency and recovery. Within us all is the power to access recovery and resiliency and this is a guide to move you forward in thinking about where you want to be and what you want to be doing with – *your* life. Let's discuss the Nebraskan qualities of resiliency and recovery.

Resiliency is about adaptation after encountering a stressful event, like trauma, death, divorce, natural disasters, threats, poverty, maltreatment, war, or encountering a physical or mental disability in the family (APA, 2011; Masten 1997). Resiliency is a "self-righting tendency." Children often have a natural ability to self-right or bounce back. The resilient child recognizes a stressful event, often responds emotionally, recoils temporarily, then bounces back and returns to a prior emotional state figuring-out in his own way what he can do to manage the difficult situation (Ginsburg KR, Jablow MM. Building Resilience in Children and Teens: Giving Kids Roots and Wings. Elks Grove, IL: American Academy of Pediatrics; 2011). There needs to be a balance for children between stressful events and having enough protective buffers in place to help them cope. When stressors outweigh the protective factor, even the most resilient child can develop problems (Ginsburg KR, Jablow MM. Building Resilience in Children and Teens: Giving Kids Roots and Wings. Elks Grove, IL: American Academy of Pediatrics; 2011). Resiliency is about how children "make it", manifestations of competence, ability to thrive, mature, & increase competence, does not mean unscarred (Masten, 1997; Ohio State Bulletin, 2011).

Adults have the power of resiliency also. We have a self-righting tendency even in our adult brain development (reference).

Many people have personal preferences on how they define Recovery. That makes perfect sense, because recovery is individually defined and very personal to each individual. SAMHSA has defined recovery as having the following guiding principles for both mental health and substance abuse related recovery:

- **Hope**
- **Person-Driven**
- **Many Pathways**

- **Holistic**
- **Peer Support**
- **Relational**
- **Culture**
- **Addresses Trauma**
- **Strengths/Responsibility**
- **Respect**

There are 4 major dimensions that SAMHSA suggests support recovery:

Health: overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;

Home: a stable and safe place to live;

Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and

Community: relationships and social networks that provide support, friendship, love, and hope.

Nebraska's Administrative Code 206 defines Recovery as: means a process of healing the mind, body, and spirit; inclusive of transformation of individuals with behavioral health conditions (consumers), family and friends, communities, and care systems to equip the person to exercise their choices and rights. This transformation or change can influence individual goals, roles, skills, attitudes that result in moving from hopelessness to hopeful life, dysfunctional relationships to quality relationships, and from illness to wellness.

Individuals and Family Members that live lives full of resiliency and recovery frequently get involved in the behavioral health system to create opportunities for people like themselves. One such place to become involved is the OCA People's Council, which was asked to assist in interpreting what the law means when it says "involve consumers at every level" of the behavioral health system. In 2013, the OCA People's Council was asked to define consumer involvement. The people of the council said that consumer involvement was providing meaningful and active input, something more than a rubber stamp, to the work of creating behavioral health services from the beginning. Meaningful input is

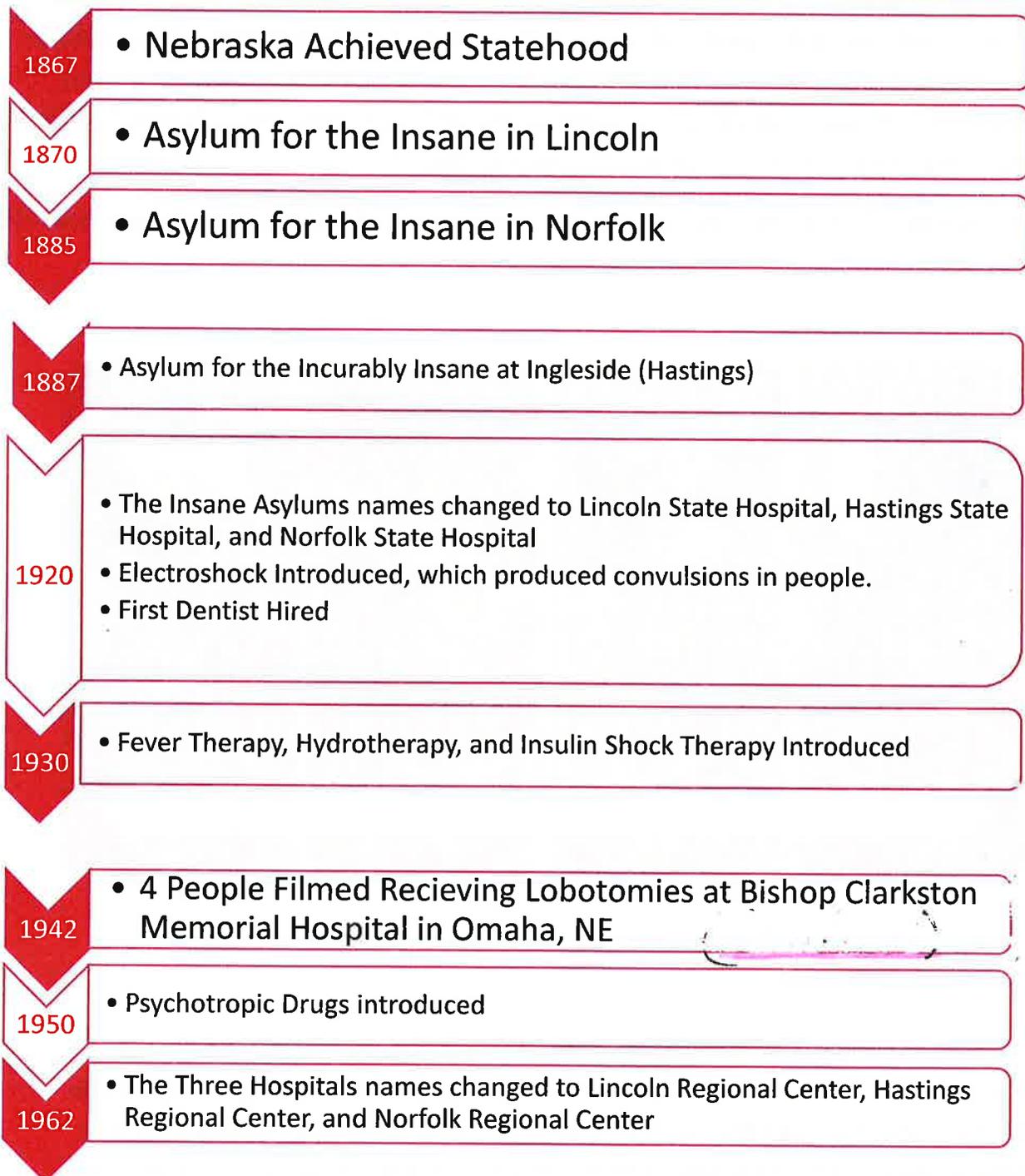
consumer driven and affects the decisions that are made about service delivery and design. Involvement is shared leadership at all levels, a voice and a choice, at the level of the system, policy, programmatic, and practice. Further folks stated that they would like to see people that self-identify in all positions in addition to addressing diversity. Special populations, like veterans, should be recognized. Folks should work to reduce barriers to involvement, like transportation. Finally, some people don't understand what a 'consumer' is. It is important to define our words.

The council was asked to define what levels are involved in inclusion and folks stated:

- State Level Behavioral Health
- Regional Behavioral Health Authorities
- Universities that address Behavioral Health
- Department of Transportation
- Advocacy Groups

The current Mission Vision and Core Functionality of the Office of Consumer Affairs is under public review, but this is the draft language being proposed that will be modified after input is gathered across the state:

2. NEBRASKA CONSUMER AND FAMILY MOVEMENT HISTORY



It is important to remember that older survivors of behavioral health services in Nebraska, remember a time of when forced lobotomies and sterilization were

considered medically necessary. Lobotomies were introduced in the United States by Walter Freeman and James Watts. It wasn't until the 1970's when lobotomies were stopped. Through 1917-1963, the United States government sanctioned sterilizations. In Nebraska, 902 citizens were sterilized, 53% were women, 80% were labelled "mentally deficient", and 18% were labeled "mentally ill". Nebraska ranked 14th in sterilizations in the US.

In the table below you can see the decline in hospitalizations in Nebraska over the decades:



In 1990, the nation developed the first Office of Consumer Affairs in New Hampshire. In this same year, Nebraska received a \$425,000 grant from the National Institute of Mental Health to implement consumer involvement in system decision making and to hire a mental health consumer. In 1991, Dan Powers and Phyllis McCaul were hired as Consumer Liaisons. One year later, the National Association of Consumer Survivor Mental Health Administrators formed. In 1994, the first mental health consumer conference was formed in Nebraska.

The Nebraska Behavioral Health Reform Act was implemented by LB 1083 with an emphasis on the concept of recovery and the regions coordinating consumer involvement in all aspects of service planning and delivery with the newly developed Office of Consumer Affairs in 2004. This same year, Dan Powers vision of a national memorial was introduced to the National Association of Consumer Survivor Mental Health Administrators. This vision resulted in a national effort to advocate and coordinate a national memorial for people at St. Elizabeth's hospital in Washington, DC.

In 2005, Nebraska Advocacy Services produced a "Peer Summit" with consumer involvement leaders, like Dr. Jean Campbell, Peggy Swarbrick, and Shery Mead. The concept of Peer Support Services and Consumer-Run Services in the Mental Health System was introduced to Nebraska. Consumer advocacy and partnership were part of the agenda as well.

One year following this event, Joel McCleary was hired as the first leader of Nebraska's Office of Consumer Affairs as part of the LB 1083 Implementation Plan. In 2007, the Division of Behavioral Health contracted with the Regional Behavioral Health Authorities to form hire Consumer Specialists in each Region.

In 2009, the Division of Behavioral Health received a Transformation Transfer Initiative Grant from the Substance Abuse Mental Health Service Administration that resulted in the forming of the first peer support training program for adults that was designed by the leadership of Heather McDonald, Chyrell Bellamy, Shery Mead, and Chris Hansen. This trauma-informed training was chosen by a consumer-led committee. This same year, the Alternatives Conference came to Omaha, NE. Alternatives is a national conference that showcases the work of consumer leaders. The Mental Health Association released the Nebraska's Consumer Voice: Leading a Change in Mental Health Services and Peer Support ranked number 4 in priority for Nebraskan's surveyed in this report. The first ever consumer-run respite facility opened, Keya House, from the Mental Health Association as well.

In 2010, the Office of Consumer Affairs hosted the first Peer Support Training and the OCA Facilitator's Circle formed that delivers the statewide training. The OCA Facilitator's Circle developed a Code of Ethics for Peer Support and Wellness Specialists. In the following year, the OCA Facilitator's Circle assisted in

developing and designing the quiz to certify Peer Support and Wellness Specialists.

In 2012, the Office of Consumer Affairs founded the OCA People's Council and the Open Door Call to improve consumer involvement. The OCA People's Council is a forum of people with lived experience with behavioral health conditions that hold administrative service positions and/or represent the individual voice of lived experience. The OCA Open Door Call is the first open call for anyone one in the community to openly dialogue with the OCA about the work that we do.

In 2014, the Public Policy Center of Nebraska found the quiz to be a valid certification tool. Education and networking opportunities expanded for this workforce and other across the state in 2011 with the first annual Success, Hopes and Dreams Conference sponsored by the Division of Behavioral Health, the Regional Behavioral Health Authorities, and other stakeholders and hosted by the Mental Health Association of Nebraska.

3. CONSUMER AND FAMILY ROLES

Prior to the President's New Freedom Commission report on Mental Health Services, consumer and family involvement was not the focus that it has become today (Bluebird, 2008). Consumer roles have bloomed and created opportunities for transformation, healing, and respect (Bluebird, 2008). This is evident in the 2014, Survey on Peer Support conducted by the Division of Behavioral Health.

Peers take on roles in hospitals and all kinds of support groups that do not take place in the provider or peer-run agency. These roles include being providers, peer-run providers, evaluation of treatment services, Offices of Consumer Affairs, statewide peer networks, and alliances with treatment and mental health professionals (Allen, Radke, and Parks, 2010).

Peer support groups often begin with a single individual or small group wanting to meet their own specific need for support. Peer-run organizations are often the

outgrowth of these groups as they grow and develop creating more groups to address identified need.

A) IN OUR OWN LIVES

Self-Help-

Self-Determination

B) IN ADVOCACY & POLICY

Consumer Advocacy Groups

Consumer-Run Advocacy Organization

Family Advocacy Organizations

C) IN PROVIDING SUPPORT (INFORMAL PEER SUPPORT)

Unpaid and naturally occurring peer support

D) IN PROVIDING PEER SUPPORT (FORMAL PEER SUPPORT)

Peer Support

Peer Support Groups

Consumer-Run Organizations as Service Providers

Family Advocacy Organizations

To further the development of peer services in our state, Director Scot L. Adams, Ph.D. has directed the Office of Consumer Affairs to formalize the current certification process with regulations that will add the force of law to the training and certification process. The 2014 survey found that while not everyone supported this process, the majority would hire a peer certified with a more formal certification, or credential as it is termed in the survey:

Do you believe that Peer Support Specialists should be credentialed professionals, recognized and regulated by the State?

	Response #	Percent
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If a formal, regulated credential existed in Nebraska, would you employ a credentialed Peer Support Specialist?

	Response #	Percent
Yes	81	65.9
No	7	5.7
Don't Know	35	28.5
Total:	123	100
Yes	60	48.8%
No	39	31.7%
Don't Know	24	19.5%

The Office of Consumer Affairs is responding by developing a regulations to support the certification process. There currently is a workgroup designing a draft of materials that will be toured around the state for public comment. After gathering public comment, draft regulations will be crafted and further refined by the public comment offering from the Attorney General's Office. This table shows our current timeline:

Phase One	Phase Two	Phase Three
March 2014 – March 2015	April-May 2015	June 2015+
Certification Review Process Workgroups Stakeholder input		
	Regulation Development Cert Process Development	
		Regulation Hearing Process Final edits AGs

4. RECOMMENDATIONS

A. Recommendations for Individuals and Families to get involved:

Individuals can get involved in making active decisions in their lives, like voicing their opinions to treatment providers, reading and co-authoring their own treatment plans. Asking schools and workplaces to provide the necessary accommodations that allow them to do the same work that everyone else does side by side.

Sharing of a recovery story with family and friends, or even the media is another way to become involved. There is a lot of misinformation about who we are in the community and the more we share we can right the lens of our fellow community members. It's important to share what is comfortable to you and not to share more than you are ready to share. Expanding the worldview of others is a tough job and having support from others is also important.

Many people struggle with the idea of whether or not to request accommodations on the job and it is important to choose what is right for you. Living a life where one is open about a behavioral health condition can be tough, but having the right supports can be nice too. Everyone has to make their own decisions and asking for information about your rights from the ADA experts is often helpful.

Getting involved in the some level of the behavioral health system can be rewarding when change happens, and can be frustrating when change doesn't happen as quickly as one would like. There are lots of places in the Nebraska to volunteer and/or work, including community organizations, statewide advocacy groups, regional groups, and the work of the Nebraska's state behavioral health authority.

Community organizations vary in each city, town, or region. It's important to realize while every community organization may not directly be a behavioral

health community group, they may impact behavioral health wellness. Examples include the school systems and writer's groups.

Statewide advocacy groups in Nebraska include, but are not limited to, organizations like National Alliance on Mental Illness- Nebraska Chapter, the National Alliance on Mental Illness of Nebraska, the Nebraska Federation of Families, and more. These organizations also have national affiliations. People can apply to be on the boards of state or national organizations. These organizations also provide services to the community where one can get involved in the practice of peer support.

Regional groups include the Regional Behavioral Health Authority. The state contracts with the Regional Behavioral Health Authority to provide behavioral health services. Each region has governing boards and advisory group opportunities for involvement. There are multiple positions at each region that one could even apply to, if qualified. The State Division of Behavioral Health contracts with each region to hire a Regional Consumer Specialist. Some regions even hire 2 Regional Consumer Specialists. This role is one where the person has lived experience with a behavioral health condition. Contacting a Regional Consumer Specialist is a great way to partner with the system and learn about teams and committees one can join.

The Division of Behavioral Health is the state mental health authority for the state of Nebraska. The governor appoints a director that leads a team of representatives with expertise in a variety of policy, planning, and program designs. The Office of Consumer Affairs is a member of the Division of Behavioral Health team. Consumer Involvement is one of the main tasks of the Office of Consumer Affairs (OCA). The OCA organizes all kinds of opportunities for consumer involvement and this is just a few:

Calling us toll free 800-836-7660

The OCA Facilitators Circle: there are 9 peers trained as facilitators in the Nebraska Peer Support and Wellness Specialist Curriculum. These individuals have been through two trainings: one in peer support and another in facilitation of the Peer Support and Wellness Specialist curriculum. The

facilitators were selected by an open public invitation to apply to the training. For more information see the Certified Peer Support and Wellness Specialist Website at:

OCA Peer Support and Wellness Specialist Certification Program: The OCA hosts one to two trainings per year. The applicants are selected through an open public invitation to apply to the training. For more information on the program, see the peer support training tab on our website or _____.

Peer Support and Wellness Specialist Co-Supervision: The Certified Peer Support and Wellness Specialist are invited to provide supervision to each other during several quarterly calls hosted by the Office of Consumer Affairs.

The OCA People's Council: The OCA hosts a council to advise the OCA on its agenda and occasionally the Division on Division agenda. Information from the council is collected by the director of the Office of Consumer Affairs, Carol Coussons de Reyes. The members were selected by an open public invitation to apply to the council membership. For more information see the website at:

OCA Open Door Calls: The Office of Consumer Affairs hosts open door calls for anyone that would like to learn more about the OCA or share information and resources. These calls are hosted monthly and the schedule is posted on our website. For more information see the schedule at:

The Statewide Behavioral Health Conference: The Office of Consumer Affairs began the Statewide Behavioral Health Conference by contracting with the Nebraska Mental Health Association annually to host the event. There are workshop presenter and scholarship opportunities offered by open public invitation. See applications when available at www.nebraskastateconference.org

Antler's Artists Shows, Recovery Jams, and Recovery Film Festivals: The Nebraska Recovery Network hosts art shows, recovery jams, and film festivals that are open to the public via contract with the Office of Consumer Affairs. For more information call 402-434-3965.

NAMI Trainings for Support Group Leaders: The Office of Consumer Affairs contracts with NAMI to host trainings for support group leaders. For more information call NAMI at 402-345-6264.

The Division of Behavioral Health itself has several opportunities for consumer involvement also:

There are 3 Regional Centers in Nebraska, with only 90 psychiatric beds.

The Division of Behavioral Health has two advisory committees, one for substance abuse and one for mental health. Occasionally both groups convene together as a Joint Advisory Committee. To be appointed to one of these committees one simply applies to the governor's website to seek appointment. All meetings are open to the public and present an open time for public comment that one can sign up for on the day of the meeting at the meeting location. To learn more visit the committee's respective website.

The Statewide Quality Assurance Team includes several members of the public that provide their perspective to the data collection and analysis process as well as quality improvement. See appendix item ____.

Legislature: Vote, hold office, contact legislators. Attend hearings. Help others register to vote.

Ombudsman's Office- visit long term care facilities, join teams, problem-solve

Judiciary : Meet judges and law enforcement officers to model recovery, communicate positive influence of their work. Show them the successes of recovery. Help them understand processes which lead to your recovery.

Mental health boards- learn about MH Boards online at DHHS. Suggest improvements to training. Meet officials to help demonstrate recovery. Develop positive relationships in case of crisis to help all understand how recovery can best be developed.

B. Recommendations for Providers

The OCA People's Council was asked for feedback on a Consumer Involvement Plan in 2012 and what they came up with is a list of considerations for providers:

1. Go to Consumers and Families to get your information first.
2. Listen to Our Stories, they are important and valuable.
3. Create cultural shifts by hiring people with lived experience in executive positions.
4. Realize the value of the Regional Consumer Specialists in creating a consumer and family driven system.
5. Consumers and Family voice should drive the system and not executives.
6. Share leadership decision making with consumers and families, hear Our Voice.
7. Shared power versus hierarchical power is very important to consumers and families.
8. Cultural Competency includes the practice of hiring people with lived experience to work with people with lived experience.
9. Minimize expressions of power that separate visibly wherever possible, like displaying badges or having staff only bathrooms.
10. Conduct environmental scans and look to reduce symbols of power and create more natural, less institutional, environments.
11. Involve consumers and families in creating system goals.
12. Realize that job stress can make the workforce ill. Create supportive environments that support people with lived experience in doing their work.

Other considerations include the following:

Being trauma informed is no easy task, it requires skill building of the mind and listening to the heart that may be experiencing compassion fatigue. Compassion fatigue is an impairment in the ability to care after a person experiences trauma or burnout. There is also a desire for folks to be trauma responsive that is actually doing something about a persons' trauma disclosure. Trauma capable means that you can be trauma responsive with trauma-specific services.

Trauma informed environments are inviting and minimize signage and other indications that may remind people of trauma in institutions. Welcome signs, plants, soft lighting, and comfortable places to sit all encourage a trauma informed environment. Asking people if they would like a simple glass of water, may bring a feeling of comfort than just receiving a usual greeting.

Policies and procedures should encourage the spirit of partnering versus the spirit of having power over an individual. While there may be rare times that a treatment plan would impair a person's ability to function, largely one should easily be able to access notes and files to understand the work that is being offered to them.

Another important action is to be person-centered and family-centered, in the instance of children. Services are based on individuals and families, and not cookie-cutter approaches. The center of the service is on the relationship with the person or the family with the child at the center. Services are focused on important life goals for the family or individual. Resiliency and recovery are the heart of the care provided. Family or Individual self-sufficiency and responsibility is emphasized. The planning incorporates growth and change and is not static.

Language should promote inclusion, respect and dignity, honor and dignity of individuals and families. These recommendations were developed by reading the National Association of State Mental Health Program Directors Older Persons Division (NASMHPD OPD) Language Guidelines, 2013. When speaking to individuals and families with behavioral health conditions, language should include the following:

1) Person-First:

Refer to the person by name and not their diagnosis in conversations to illustrate the humanity and personhood of the individual. This should take place in public and private conversations in representing people with behavioral health conditions. Refer to groups of people in terms of roles and not their disability or health condition.

2) Examples of Person First Language:

- 3) People with behavioral health condition's lives should be referred to in hopeful terms with a focus on meaning and purpose.
- 4) Do not refer to people as cases. Use the term "Service/Resource Coordination" or "Participant" over the offensive terms like "Case Management" that refer to people as "Cases".
- 5) Do not use the term "Compliance", which implies people have impairments or defective behavior. The proper term is "Adherence".
- 6) Do not use the term "Mental Illness" whenever possible, use "Mental Health Condition" which implies mental health is a condition of overall health like any other condition.
- 7) With awareness of discrimination and oppression in our culture, avoid "us-them" language, like referring to people as "our consumers". Avoid referring to diversity a negative light, like referring to a bad situation as "crazy".
- 8) The word "stigma" refers to people as marked and therefore should not be used. The preferred term is "discrimination", which refers to the social role of what is happening to an individual.
- 9) Terms like "Chronic or Frequent Flyers" have negative connotations. Preferred language would be "severe" or "persistent".
- 10) While the language of "consumer" may be preferred by many nationally and individually by people in many places, "consumer" is another label. The best language refers to citizenship or personhood. Even "patient" is another label. We strive for "person-centered" care, not "patient-centered".
- 11) "Complex" is a positive way of referring to an individual with multiple conditions, versus more hopeless language like "Difficult".

Services should be recovery-oriented in that they are encouraging everyone to learn and grow to their full-potential. This area may be challenging in medical model environments where documentation requirements seems to focus a person on major challenges versus encouraging strengths.

Medical Model

- ▶ **Established Practices**
- ▶ **Long Term Hospitalization**
- ▶ **Staff Directed Care**
- ▶ **Stabilization**

▶ **Be Obedient and Comply**

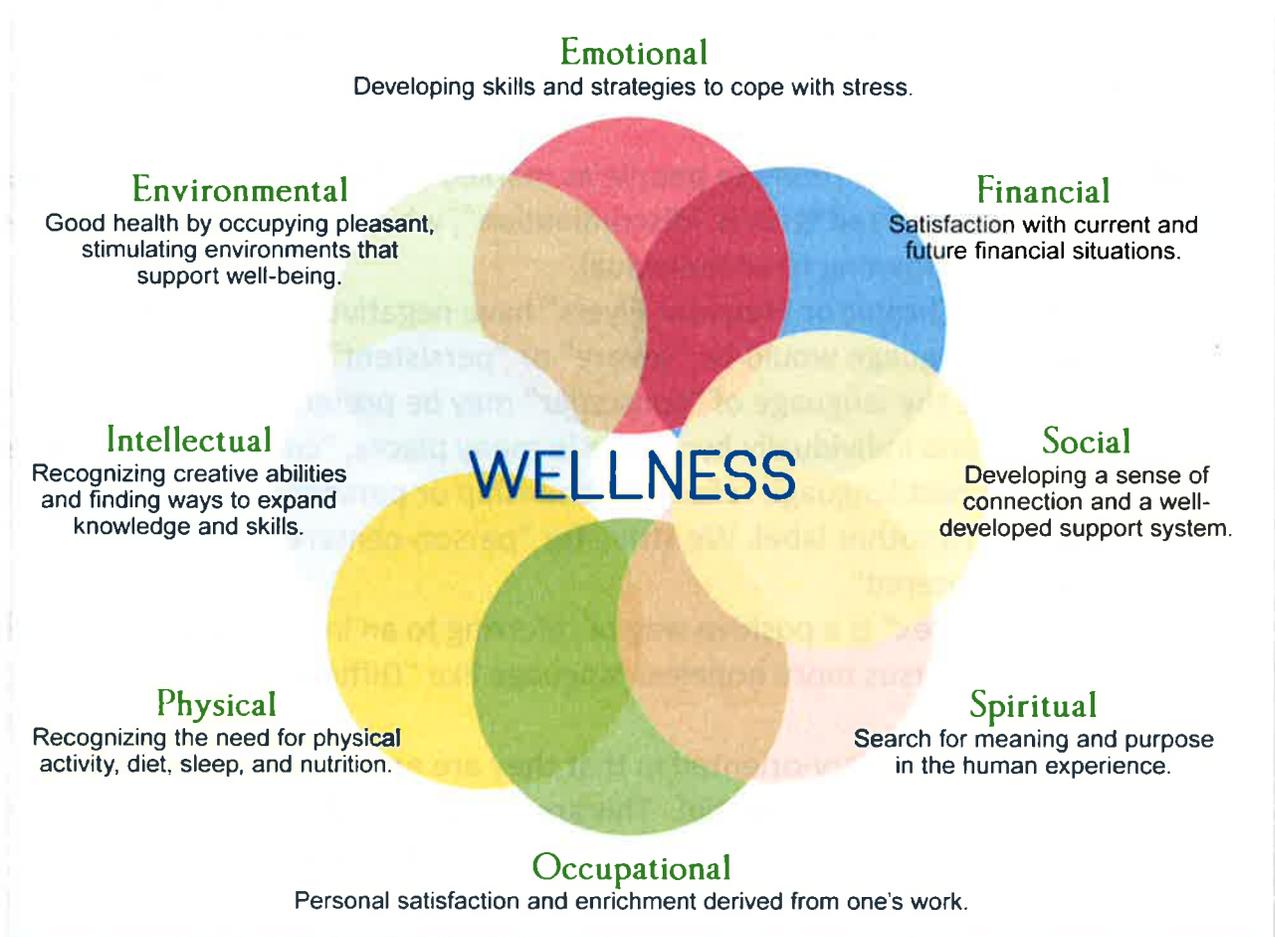
- ▶ **Diagnose Disease**
- ▶ **Will not Recover**

Recovery Model

- ▶ Emerging Practices
- ▶ Community Based Care
- ▶ Shared Decision Making
- ▶ Education

- ▶ Self-Advocacy/Self-Help
- ▶ Prevent Crises
- ▶ Can and do Recover

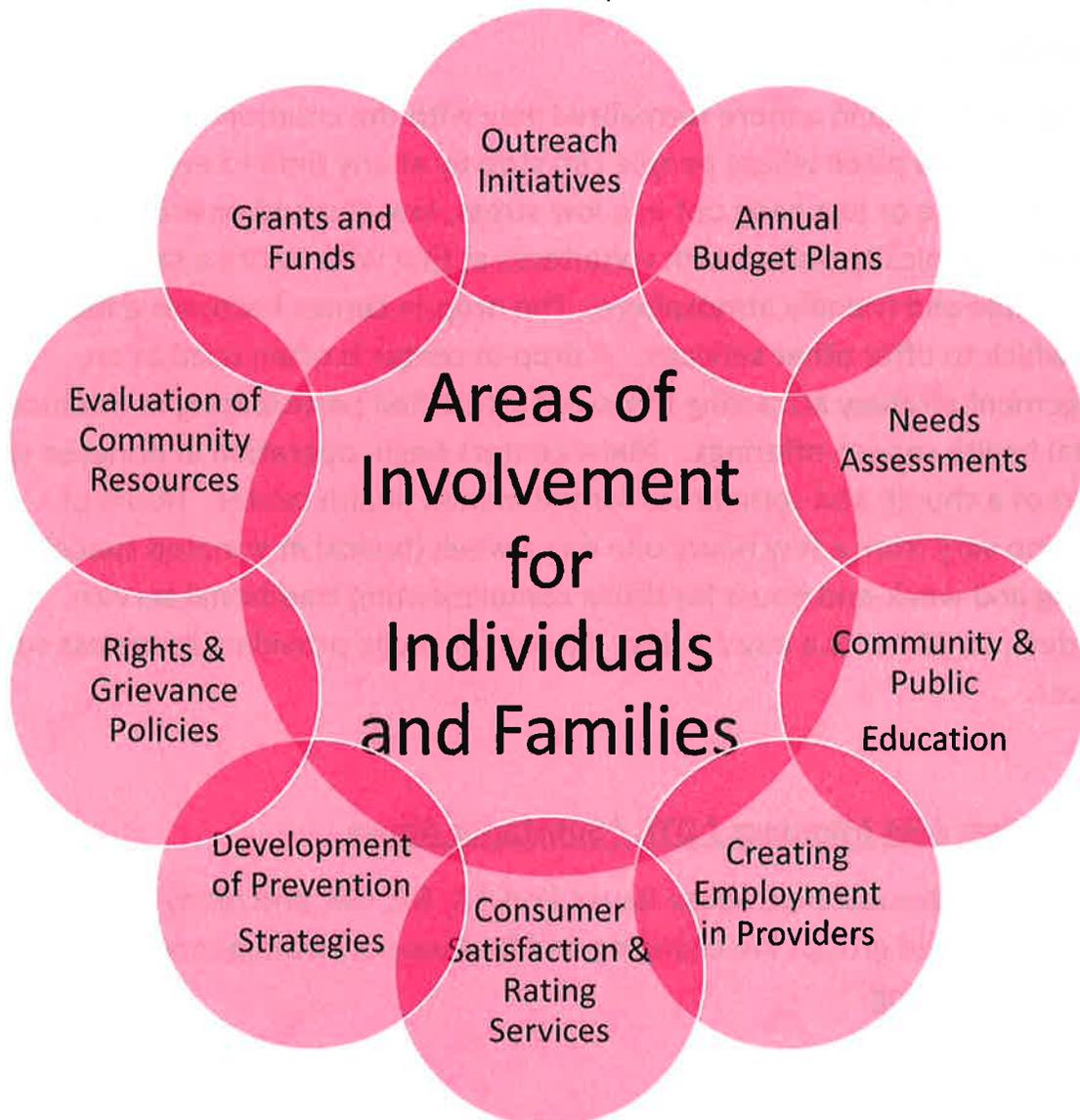
Another area of focus is the overall wellness of the individual’s mind, body, and spirit. This table was published by SAMHSA in 2012 that describes all the many considerations in focusing on individual wellness:



Nebraska’s behavioral health system could deliver services in a culturally and linguistically competent manner to consumers served by Nebraska’s State Hospitals and by contracted community service providers. Areas of focus include integration into division policies, provider requirements and service contracts, an advisory committee on cultural and linguistic competence could

provide ongoing leadership and guidance in continuously improving cultural and linguistic competence of the service system, standards for linguistic services could be updated based on statewide “needs assessment” and review of latest research. Cultural competence training programs could be identified and promoted to enhance staff ability in providing culturally appropriate service. Strategies could be developed to assess culturally competent community service agencies and Nebraska’s State Hospitals.

There are several domains of areas that providers and regions should seek involvement from families and individuals, these domains include:



APPENDIX

A. Writings of John Allen:

Drop-In Centers

Many groups begin in a more formalized way with the creation of a drop-in center. This is a place where people can stop by at any time to enjoy a cup of coffee, socialize or just hang out in a low stress, low demand environment. Centers are typically staffed with volunteers at first who insure a safe, comfortable and friendly atmosphere. The drop-in center becomes a focal point from which to offer other services. A drop-in center is often used as an engagement strategy attracting those not interested participating in traditional mental health service offerings. Many centers begin operation in donated space as part of a church and sometimes formal mental health center. Hours of operation vary from a few hours one day a week (typical in donated space), to evening and week-end hours for those complimenting traditional service providers, to 24 hours a day / 7 days a week for those providing homeless support services.

AA Meetings / NA Meetings / DTR / Substance Abuse

Individuals with substance abuse issues find AA, NA, GA, and many other addiction-related groups life changing and find support from peers in this anonymous setting.

Individuals who have used mental health services often identify co-occurring substance use as an issue they would like assistance with. For this reason, many

peer support groups and drop-in centers offer or support substance abuse groups like AA (Alcoholics Anonymous), NA (Narcotics Anonymous) or DTR (Double Trouble and Recovery) by holding meetings at their locations. Specialized groups like DTR address the concerns of people who use psychotropic medications in ways that some typical AA meetings can't (some groups require no drugs of any kind including prescriptions). Groups often begin by partnering with a AA , NA or DTR group offering space and refreshments. Some drop-in centers have volunteers and or staff with training and backgrounds specific to facilitating a group.

Advanced Directives / Wellness Recovery Action Plans

As support groups develop and peers gain more experience in their personal recovery journeys, assisting peers find ways to insure their treatment preferences are respected and followed is a natural development. Advanced directive training and support follows with groups providing information, education and some offering workshops. Some groups take the legal concept of advanced directives to incorporate treatment preference planning beyond just a crisis plan. Most places that provide workshops recommend that an advanced directive be developed over a period of time in discussions with the supports that an individual desires. In this way, the people providing support know the exact preferences of the individual they are supporting and under what circumstances they should take action. This service provided by a peer support group in a traditional provider setting, can create opportunities for traditional mental health staff to not simply understand the preferences of their clients, but can allow them to create service options that actually promote recovery. Wellness Recovery Action Plans (WRAP) is a process many peer organizations endorse which supports each individual in creating a plan for themselves through structured discussions and activities. Many peer groups offer members, volunteers and staff the opportunity to attending WRAP facilitator training so that they are credentialed to run WRAP groups.

Advocacy / Advocacy Training

In the past, most mutual support groups for mental health recipients were begun as a way to change the system. Individual and systemic advocacy is a service that many peer support groups still perform both as a way of assisting members in addressing issues and a method of engagement of new members. Advocacy has also taken new directions as some jurisdictions employ peer support groups to gather input into governmental processes. Other groups provide individual advocacy training to enable members to become better self-advocates. There are peer support groups that contract with the federal PAIMI (Protection and Advocacy for Individuals with Mental Illness) agencies to act as lay advocates and do case finding. Some service systems provide advocates contracted from peer support groups to assist individuals in navigating complaint and grievance processes or other part of the system.

Benefits Advisement

New people receiving mental health services and individuals who have been in the system who desire to work, often seek guidance from peers on benefit issues. Many peer support groups provide benefit education and assistance ranging from social security supports (SSI / SSDI), Medicaid, Medicare to emergency energy assistance. With the turnover rates for mental health workers being high, individuals who have been in the system are the best source of practical information on benefits. Many programs, like those from Cornell exist to provide training for individuals in peer support groups on benefits advisement.

Career Club / Employment

As peer support groups are and grow in membership issues of recovery often begin to focus on employment. Coupled with benefits advisement which is critical when considering work, peer support groups have created job/career clubs to provide mutual support for members seeking and struggling with returning to work. Coupled with traditional employment or job coaching services, this mutual support activity provides a unique assistance to aid individuals in transitioning from an individual identity of a disabled person to that of productive

employee. Some peer support groups have created agency run business enterprises as a way of creating supportive job opportunities for members.

Clothes Closet

Depending on the needs of peers, some peer support groups working with other community organizations provide a “Clothes Closet” for peers enabling members for example to find warm clothing in the winter when they lack financial resources. Often these are as simple as a closet in the drop-in center in which people place clothing they no longer want that others can search. In some peer support groups this activity has grown to the point of an agency run thrift shop that generates both employment opportunity for members as well as income for the group.

Community Meals / Kitchen

In starting a peer support group, one will find that an easy way to entice new members is provide food. Many peer support groups offer community meals as a way also of addressing member’s issues in making limited financial resources stretch. Peer support groups that provide homeless services find that meals become a necessity to meet the needs of their members. No matter the reason that a peer support group provides meals, they become an attraction and engagement tool for finding new members and building a true community of support for existing members. Meals are frequently begun as pot-luck suppers where each member agrees to bring one item to share. Working with food pantries and extension agents, community meals can provide opportunities to teach meal preparation and nutrition to members enabling them to stretch their limited food budgets. Often formal Peer Support Programs have a snack shop that is completely operated by peers.

Computers / Internet Access

Once a peer support group grows, its need for a computer to keep records and write reports necessary to satisfy funding sources becomes critical. Groups have

found that making that same computer available to members to aid in resume writing, and job searches addresses immediate needs. Some groups augment their single computer by seeking donations from companies like insurance carriers that regularly replace their equipment upgrading it. This has created an opportunity for these peer support groups to establish computer training programs which in some cases include industry standard certifications recognized by Microsoft and Novell as well as employers. Internet access is frequently available at free or reduced rates from local internet providers once the group has it's non-profit status. This allows the groups members to conduct their own research and education on topics such as medications, diagnosis, wellness self management, or other topics of interest. Some peer support groups serve as pre-vocation site and even vocational employment training sites for the traditional service system.

Crisis Respite Support

Peer-Run crisis respite programs provide an alternative to hospitalization, when that is a service that does not really work for a person anymore. The individual comes to the respite center when they are well, and establish mutual agreements with peer staff as to how to assist them during a crisis. Often the peer staff are trained in a model of peer support, like Intentional Peer Support, that assists individuals in utilizing respite as a learning experience. These are active places that call for individuals to engage their life differently and create movement, and not just a place of relaxation.

Warm Lines

Warm lines are not crisis lines, they are a way for peers to access peer support through a telephone. Having someone to call daily, weekly, or monthly can prevent the ordinary from becoming extraordinary. They can be very useful in rural areas. It is really important that warmlines are closely networked with community resources to refer individuals and that the peer operating them are trained on what to do if someone calls the line with a crisis which the line can not address.

Food Pantry / Nutritional Assistance

Many groups, particularly those that have established community meals, begin to explore creating food pantries in collaboration with local food banks. These pantries provide members with low cost or emergency food options that enable individuals living on the fixed income from disability to be able to maintain a healthy diet. Some programs also work with local cooperative extension or homemaker services to provide education on meal planning and preparation as part of their service.

Forensic Support / Jail Diversion

In some areas, peer support groups who have members involved in the criminal justice system provide a variety of support activities specifically aimed to help re-integration and maintenance of positive community involvement. As groups have provided training and support to local law enforcement, some groups have developed a variety of formal and informal mechanisms to assist with diversion activities. These typically involve crisis support for individuals whom police are called as a result of unusual behavior.

Housing

Some of the earliest peer support groups created a variety of informal housing options in which members shared resources in the same way that non-disabled individuals room together. This had led to the creation of a variety of housing options including peer support groups operating HUD section 8 housing programs, providing McKinney Homeless housing services and building Habitat for Humanities housing. Working with local NAMI, Mental Health Associations and local Habitat for Housing, some peer support groups build on a program stated in Georgia called “Jerome’s Home” to creates home ownership opportunities for individuals in the mental health system.

Laundry

As groups grow and established permanent drop-in centers, some create the ability of members to meet their laundry and cleaning needs. This is especially true for groups that provide support to individuals who experience homelessness. Although laundries do exist, many individuals who are homeless find that they are not welcome at those establishments, so peer support groups become their only option.

Lending Library

Although public libraries can often address the need for information on recovery, many peer support groups maintain literature and publications on everything from medication to legal rights. These libraries of information are often used by the groups as part of their member educational efforts.

Literacy Training / Education Support

Depending on the community and its members, some peer support groups collaborate with basic literacy education programs to assist members with basic reading skills or attainment of G.E.D. diplomas. Other groups augment disability services frequently available on college campuses to support members who are furthering their education through college or vocational classes.

Mail Service

Peer support groups that have a number of members who experience homelessness or live in transitional housing will sometimes create mail services. This sometimes looks like a post office with locked mail boxes for each individual and is sometimes as simple as acting as the address for those that lack stable housing enabling them to receive mail.

Newsletters

Almost all peer support groups develop a newsletter as a way of keeping their members informed of events and activities. Some newsletters in addition to center news, publish member poetry, art, short stories, recipes, book and travel reviews. Newsletters are an excellent method of marketing the peer support group as well as disseminating valuable information to members.

Another use for newsletters is to describe places that are friendly to peers in the community through the eyes of the peer themselves.

Parenting Support

It is important to acknowledge this important social role that many individuals that utilize services have. In this area, peer support groups have created a variety of support mechanisms including parenting education, support groups and even in a few places respite / babysitting services. Other groups have focused on advocacy are parental rights, often with child custody issues taking the forefront.

Peer Support Programs

Peer Support programs often provide groups whose content is determined by all the peers that are a part of the program together. Those served by the program teach peer groups on topics that promote wellness, as well as the peer facilitator employed by the program. Often folks attending the program graduate from the program to venture into other activities like college, work, or other initiatives.

Rep Payee Services / Budgeting and Money Management

Many individuals on Social Security benefits have the need for assistance in managing their funds through a representative payee. In some cases, individuals are mandated because of prior money management or chemical addictions to have a payee. Since it is often difficult to find someone willing to accept the responsibility as a payee given the lack of funding for this service, peer support groups in many areas have provided training and staff to assist members as a representative payee. In some instances, peer support groups have expanded

their efforts to assist members learn better money management skills. Some have a member who is an accountant offering their services assisting with tax return preparation.

Speakers Bureau

Peer support groups frequently develop speaker's bureaus for a variety of reasons. The most common are to enhance their marketing efforts for new members, public education regarding recovery and stigma, and to support their fund-raising efforts. Speakers Bureaus provide members with a variety of opportunities for personal growth and development in addition to de-stigmatizing mental health in the community. Some groups partner with organizations like Toastmasters International to assist members with public speaking skills.

Social Recreation Events

As groups grow and people form natural relationships within the peer support group, the desire to social recreation activities expands. Many peer support groups offer social recreation opportunities both to meet member needs, but also enhance their marketing efforts for new members. Social recreation provides opportunities for members to continue to build their own natural support networks as well as simply have fun. Many groups plan dances, movie outings, picnics, softball games, bowling leagues and other events based on member preferences.

Support Groups

Many peer support groups identify other needs as individuals come together for support. This results in many groups developing other support groups as part of their overall efforts such as: art activities; Depression and Related Affective Disorders Association (DRADA); Emotions Anonymous (EA), men's groups; music groups; Recovery Inc.; and women's groups.

Volunteer Referral

As peer support groups grow, providing members linkage with volunteer opportunities is almost a standard offering of all groups. Few groups begin without the ability to recruit, mobilize and manage volunteers. Some groups working with volunteer clearinghouses co-host opportunities to explore volunteering. Other groups provide information and support to members who are interested in volunteering.

What are Seed Grants for Consumer Owned and Operated Programs?

Grant opportunities provided by the Region to fund consumer owned and operated initiatives. The amount of the grant could be as small as \$50 or as large as \$5,000 given to a person that will provide a peer run business to fill a gap in the community. This could be funding to purchase WRAP books for a training that a support group is hosting or a portion of a salary to a person starting a new non-profit organization. The OCA can provide technical assistance to grant recipients in the form of understanding how to apply for larger grants and understanding the resources of their community at large, etc.

B.

This survey resulted in the following findings about the different roles of family and adult peer support specialists:

Peer Support Service Category	BH Agency	Peer Agency	Category Total:
Advocacy	53	51	104
Mentoring	49	47	96

Support Groups	40	47	87
Crisis Intervention	41	39	80
Recovery Support	51	45	96
Health/Behavioral Health Education	35	37	72
Other Supports	36	26	62

Of all 137 respondents, **108** indicated that they provided some type of peer support services directly or thru subcontract. These respondents answered additional questions. This question included descriptions of each category, and people could choose multiple options. The survey did include a broad definition of each category as follows:

Advocacy: A peer empowering a peer/family to learn self and system advocacy.
Mentoring: A peer to peer/family in a supportive relationship to improve self-help skills.

Support Groups: A group of peers/families in a supportive meeting environment.

Crisis Intervention: A peer providing timely support to a peer/family to help stabilize, reduce risk of system involvement and promote resiliency such as loss teams, family navigators, warmlines, crisis response teams, etc.

Recovery Support: A peer supporting a peer/family to promote resiliency, relapse prevention support plus long term safety and well being; such as Clubhouse, WRAP, respite, transition planning, etc.

Supportive Services: A peer supporting a peer/family to connect to community resources that support recovery and whole health; such as accessing benefits, housing, job training, etc.

Health/Behavioral Health Education: A peer empowering a peer/family with education that supports healthy living; such as parenting courses, smoke-free living, etc.

Other Supports: Aid that benefits peers such as transportation or case management but also provided by a peer.

This survey was conducted with Behavioral Health and Peer-Run Agencies and was not meant to be an exhaustive list.

B.

The 2014 survey of providers, agency and peer-run agencies, stated the following barriers need to be addressed in our system to promote the work on peer support:

Percentages of People (at Agencies) that Responded to Questions on Barriers and Resources to Benefit Capacity

Barriers and Challenges for People at Agencies in Providing Peer Support Services

- #1- Lack of **Awareness** of how to Integrate Peer Support Services **(69%)**
- #2- Non-Availability of **Resources** to Hire Peer Support Specialists (PSS) **(56%)**
- #3- Limited Availability of **Training** and Ongoing Education for PSS **(49%)**
- #4- Non-Availability of Resources to Ensure Program **Evaluation/Quality** Improvement Activities for PSS **(45%)**
- #5- Lack of **Capacity** to Implement Evidence Based Peer Support Programs **(36%)**
- #6- Cost of Providing **Clinical Consultation** for Peer Support Specialists **(34%)**
- #7- Limited **Availability** of Certified/Sufficiently Trained Peer Support Specialists **(33%)**

The 2014 survey of providers, agency and peer-run agencies, stated the following incentives need to be offered in our system to promote the work on peer support:

Incentives or Resource to Benefit Capacity to Provide Peer Support Services

#1- Awareness- Education on how to Integrate Peer Support Services **(74%)**

#2- Resources- To Ensure Employment of PSS **(68%)**

#3- Capacity for EBPs- Providing Resources to Implement Evidence Based Peer Support Programs **(64%)**

#4- Evaluation- Resources to Ensure Program Evaluation/Quality Improvement Activities for PSS **(58%)**

Training- Increased Access to Training/Ongoing Education for PSS **(58%)**

#6- Peer- Increased Availability of Certified/Sufficiently Trained PSS **(50%)**

#7- Clinical Consultation – Providing Resources for Clinical Consultation for PSS **(43%)**

C.

Public Policy Center recently lead surveys and focus groups around the current certification process and developed this list of recommendations in 2014, these recommendations are in Section 6 of the Nebraska Peer Support Certification Study:

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.

D.

Resources and Places to Get Involved:

**Network of Care Website of
Resources for Each Region**

Website: <http://networkofcare.org>

Office of Consumer Affairs

301 Centennial Mall South, 3rd Floor-DBH

Lincoln, NE 68509

402-471-7853/ 402-471-7859 (fax)

Email:

carol.coussonsdereyes@nebraska.gov

Website:

[http://dhhs.ne.gov/behavioral health/Pages/beh mh mhadvo.aspx](http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_mhadvo.aspx)

State Ombudsman’s Office

1445 K Street

Lincoln, NE 68508

(402) 471-2035

Website:

<http://www.nebraskalegislature.gov/divisions/ombud.php>

DHHS Systems Advocate (Helpline)

PO Box 95026

Lincoln, NE 68509-5026

Toll Free: 1-800-254-4202

Website: www.dhhs.ne.gov

Nebraska Family Helpline

Toll Free: 1-888-866-8660

Website:

[http://dhhs.ne.gov/behavioral health/Pages/nebraskafamilyhelpline index.aspx](http://dhhs.ne.gov/behavioral_health/Pages/nebraskafamilyhelpline_index.aspx)

National Suicide Prevention and Veterans Hotline

Toll Free: 1-800-273-TALK

Website:

<http://www.suicidepreventionlifeline.org/>

Nebraska Recovery Network

2501 South St

Lincoln, NE 68502-3050

(402) 477-2372

Website:

<http://nebraskarecoverynetwork.org/>

Nebraska Mental Health Association

1645 N St # A

Lincoln, NE 68508-1824

(402) 441-4371

Website: <http://www.mha-ne.org/>

NAMI Nebraska

415 South 25th Ave

Omaha, NE 68131

(402) 345-8101

Website: <http://naminebraska.org/>

Disability Rights of Nebraska

134 South 13th Street, Suite 600

Lincoln, NE 68508

Phone: 1 (402) 474-3183

Toll-Free: 1 (800) 422-6691

Website:

<http://www.disabilityrightsnebraska.org/>

Central Nebraska Council on Alcoholism and Addictions

219 West 2nd Street, Grand Island, NE 68801

Ph: (308) 385-5520 / Fax (308) 385-5522

Website: www.cncaa.net

National Coalition for Mental Health Recovery

1101 15th Street, NW #1212

Washington, DC 20005

Toll Free : 877-246-9058

Website: <http://www.ncmhr.org/>

Faces & Voices of Recovery

1010 Vermont Ave. #708

Washington, DC 20005

(202) 737-0690/ Fax (202) 737-0695

Website:

<http://www.facesandvoicesofrecovery.org/>

National Empowerment Center

599 Canal Street

Lawrence, MA 01840

Toll-free: 800-power2u (800-769-3728)

Outside US: 978-685-1494/ Fax: 978-681-6426

Website: www.power2u.org

The Carter Center- Mental Health Program

One Copenhill

453 Freedom Parkway

Atlanta, GA 30307

(404) 420-5100/ Toll Free (800) 550-3560

Website:

<http://www.cartercenter.org/index.html>

National Mental Health Consumer Self Help Clearinghouse

1211 Chestnut Street, Suite 1207

Philadelphia, PA 19107

Toll Free: (800) 553-4539/ (215) 751-1810

Fax: (215) 636-6312

E-mail: info@mhselfhelp.org

Website:

<http://www.mhselfhelp.org/>

Depression and Bipolar Support Alliance

730 N. Franklin Street, Suite 501

Chicago, Illinois 60654-7225

Toll-free: (800) 826-3632 / Fax: (312) 642-7243

Website: <http://www.dbsalliance.org>

STAR Center

3803 N. Fairfax Dr., Suite 100
Arlington, VA 22203
Toll-Free: (866) 537-STAR (7827)
Fax: (703) 600-1112
Website:
<http://www.consumerstar.org/index.html>

The Kim Foundation

C&A Plaza
13609 California Street
Omaha, NE 68154
(402) 891.6911
Website: www.thekimfoundation.org

**Mental Health America-Consumer
Supporter****Centers for Technical Assistance**

2000 N. Beauregard Street, 6th Floor
Alexandria, VA 22311

Toll Free: (866) 439-9465 / Fax. (703)
684-5968

E-mail: ConsumerTA@nmha.org

Website: <http://ncstac.org/index.php>

**Substance Abuse Mental Health
Services Administration (SAMHSA),
CSAT, CMHS, CSAP, OCA**

P.O. Box 2345

Rockville, MD 20847-2345

Email: SAMHSAInfo@samhsa.hhs.gov

Toll Free: 1-877-SAMHSA-7 (1-877-
726-4727)

TTY: 1-800-487-4889

Fax: 240-221-4292

Website: <http://store.samhsa.gov/>

Trauma-Informed Care Peer Support

What training topics would be most useful?

- Intergenerational trauma
- Reenactment/Repetitive Reactions
- Substance Use/Trauma
- Neurobiology of trauma
- Talking to people about trauma
- Trauma & Memory
- Survivor Mission: Using Story to Heal
- Posttraumatic Growth
- Shame & Guilt
- Trauma-informed Interventions (activities)
- Information about specific trauma: domestic violence, sexual violence, child abuse,

Compassion Fatigue/Vicarious Trauma

What training topics would be most useful?

- Identifying signs and symptoms
- Resiliency Strategies
- Reconnecting to the Work
- Tracking Stressors at Home and Work
- Processing with others
- Developing Warning Systems for Self

PROPOSED OCA BUDGET FOR FISCAL YEAR 2015

F.

	FY15 amounts
PERSONAL SERVICES	
SALARIES	\$ 89,321.61
Salary - 27th Payroll	
Retirement	\$ 6,699.12
FICA	\$ 6,833.10
Life	\$ 9.00
Health	\$ 15,864.10
SUBTOTAL	\$118,726.93
4200 OPERATING	
CONFERENCE FEES	\$ 2,100.00
RENT-OTHER REAL PROPERTY	\$ 1,000.00
ED & REC SUPPLIES	\$ 3,200.00
MGT CONSULTANT SERVICES	\$ -
<i>SUBTOTAL</i>	\$ 6,300.00
TRAVEL EXPENSE	
BOARD & LODGING	\$ 3,000.00
MEALS NOT IN TRAVEL STATUS	
MEALS-ONE DAY TRAVEL	
COMMERICAL TRANSPORTATION	\$ 3,000.00
STATE-OWNED TRANSPORTATION	
PERSONAL VEHICLE MILEAGE	\$ 2,600.00
CONTRACTUAL SERV-TRAVEL EXP	
MISC TRAVEL EXPENSE	\$ 300.00
<i>SUBTOTAL</i>	\$ 8,900.00
TOTAL	\$133,926.93

OCA CONTRACTS

6.

Purpose	Fiscal Year 2015 Contracts Implemented and Proposed	Amounts
Facilitator's Circle, Connections Workgroups, and Trainings	National Alliance on Mental Illness: Nebraska	33,262
purpose of this contract is to provide a statewide conference that is positive about recovery, creates networking opportunities, showcases success, and provides a voice for addiction survivors and people living with mental health conditions	Mental Health Association of Nebraska	48,500
2 Compassion Fatigue Workshops	Region 3 Behavioral Health Systems	2,000
purpose of this agreement is to create training curricula and host training events for Family and Adult Peer Support Specialists on Trauma 101 and Compassion Fatigue.	Behavioral Health Education Center of Nebraska	25,500
purpose of this contract is to provide opportunity for consumer involvement and access to events by providing honorariums for participation in conferences, meetings, travel and recovery activities in the Nebraska Behavioral Health System.	League of Human Dignity	14,970
BH Resource Website Management provide recovery support for people by promoting and conducting recovery based activities for individuals with mental or substance abuse disorder.	Network of Care Partners in Recovery	108,000 46,500

Mental Health First Aid: *Research and Evidence Overview*

Mental Health First Aid is an international program with proven effectiveness. Five published studies in Australia show that the program saves lives, improves the mental health of the individual administering care *and* the one receiving it, expands knowledge of mental illnesses and their treatments, increases the services provided and reduces overall stigma by improving mental health “literacy”. Mental health literacy is defined as empowering the public to identify, understand and respond to signs of mental illness. Studies also found the program reduces overall stigma of mental health and even improves the mental health of program participants. A list of relevant international studies can be found at <https://www.mhfa.com.au/cms/evaluation-publications/>.

BUILDING AN EVIDENCE BASE IN THE US

Mental Health First Aid is now listed in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP). NREPP is a searchable database of mental health and substance abuse interventions to help the public find programs and practices that may best meet their needs and learn how to implement them in their communities. All interventions in the registry have been independently assessed and rated for quality of research and readiness for dissemination. The summary for MHFA can be viewed at <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=321>.

OUTCOME STUDIES: NATIONAL EFFORTS

Fidelity Study: SAMHSA provided a grant to the University of Maryland to conduct a review of the adaptation process of the MHFA USA program in regards to its fidelity to the original Australian program. Outcomes of the study are not directly related to feedback from course participants. Final report produced. *Summary of findings:* MHFA USA developed in fidelity to the original Australian program and includes adequate certification standards and procedures to ensure fidelity continues to be upheld.

Higher Education Study: National Institute of Mental Health (NIMH) supported Western Interstate Commission on Higher Education (WICHE) and the University of Michigan to conduct a 2-year study of MHFA at 32 institutions nationwide resulting in a final report. The study found that resident assistants who took the MHFA training showed increased positive affect, perceived knowledge of mental illnesses (relative to the average person), positive beliefs about treatment, confidence in assisting someone with a mental health problem and use of therapy/counseling.



**Included in SAMHSA's
National Registry of
Evidence-based
Programs and Practices**

Course Evaluation Analysis: The University of New Mexico is currently conducting an evaluation of course participant feedback. The emphasis of this analysis is on differences in response in rural versus urban course settings, as well as differences in response to the program across demographics.

Local/Regional Efforts: A number of states and cities across the country have begun to evaluate the progress of MHFA in their communities:

- *Alaska:* In 2012, Nearly 200 Mental Health First Aiders participated in a coordinated pre/post-test for all course participants throughout the state.
- *Chicago:* Community Counseling Centers of Chicago (C4) received grant from the State of Illinois to evaluate their MHFA program. The focus of the evaluation was two-fold: a process evaluation used to increase fidelity among their 10 instructors, as well as conducting pre/post testing to measure the impact of the program.
- *Colorado:* Supported by a SAMHSA Challenge grant, the Colorado Behavioral Health Council, in coordinated with instructors from across the state in order to conduct pre/posttests with all MHFA training participants.
- *Philadelphia:* Drexel University is working in conjunction with the City of Philadelphia to evaluate the MHFA program across the city. Philadelphia is looking at a population based approach to the program, with the goal of getting 10% of the city trained. The focus of the evaluation will be on Public Safety and Faith based audiences, assessing the impact of MHFA in the work, community and personal lives of public safety and faith-based Mental Health First Aiders with a focus on several key impact measures tied to the ALGEE mnemonic.
- *Kansas:* University of Kansas conducting is currently conducting interviews in order to analyze the implementation of the MHFA program across the state of Kansas. The primary focus of the analysis is on how the program has been utilized and in which sectors.

How do I get through the rough spots after I stop smoking?

- For the first few days after you quit smoking, spend as much free time as you can in public places where smoking is not allowed. (Places like libraries, malls, museums, theaters, restaurants without bars, and churches are most often smoke-free.)
- Take extra care of yourself. Drink water, eat well, and get enough sleep. This could help you have the energy you may need to handle extra stress.
- Don't drink alcohol, coffee, or any other drinks you link with smoking for at least a couple of months. Try something else instead – maybe different types of water, sports drinks, or 100% fruit juices. Try to choose drinks that are low- or no-calorie.
- If you miss the feeling of having a cigarette in your hand, hold something else – a pencil, a paper clip, a coin, or a marble, for example.
- If you miss the feeling of having something in your mouth, try toothpicks, cinnamon sticks, sugarless gum, sugar-free lollipops, or celery. Some people chew on a straw or stir stick.
- Avoid temptation – stay away from people and places you link with smoking.
- Create new habits and a non-smoking environment around you.
- Get ready to face future situations or crises that might make you want to smoke again, and think of all the important reasons you've decided to quit. To remind yourself of these reasons, put a picture of the people who are the most important to you somewhere you see it every day, or keep one handy in your purse or wallet.
- Take deep breaths to relax. Picture your lungs filling with fresh, clean air.
- Remember your goal and the fact that the urges to smoke will lessen over time.
- Think about how awesome it is that you are quitting smoking and getting healthy. If you start to weaken, remember your goal. Remember that quitting is a learning process. Be patient with yourself.
- Brush your teeth and enjoy that fresh taste.
- Exercise in short bursts (try alternately tensing and relaxing muscles, push-ups, lunges, walking up the stairs, or touching your toes).
- Call a friend, family member, or a telephone stop-smoking help-line when you need extra help or support.
- Eat 4 to 6 small meals during the day instead of 1 or 2 large ones. This keeps your blood sugar levels steady, your energy balanced, and helps prevent the urge to smoke. Avoid sugary or spicy foods that may trigger a desire to smoke.
- Above all, reward yourself for doing your best. Give yourself rewards often if that's what it takes to keep going. Plan to do something fun.

References:

- Morris, Chad D. PhD. , Morris, Cynthia W. PsyD., Martin, Laura F. MD, Lasky, Gina B. PhD Dimensions: Tobacco Free Toolkit for Healthcare Providers, Behavioral Health & Wellness Program , University of Colorado Anschutz Medical Campus School of Medicine.
- Williams, Jill MD Smoking and Schizophrenics 2011, University of Medicine & Dentistry of New Jersey

- CDC Centers for Disease Control and Prevention Vital signs Focusing on People with mental Illness February 2013
- Shirley Deethardt, DHHS Tobacco Free Nebraska

QuitNow.ne.gov

Nebraska Tobacco Quitline: 1-800-QUIT-NOW

How to Cope with Withdrawal Symptoms

Feeling irritable, moody or tense

Do relaxation Techniques: Deep Breathing, Visualization, Muscle relaxation, or Listen to music, take a bath or shower, or do some light stretches.

Cravings

Brush your teeth.
Drink a glass of water.
Take a walk or exercise.

Headaches or dizziness

Sit or lie down and close your eyes.
Do relaxation techniques.

Dry mouth or sore throat

Drink a glass of water.
Suck on ice.

Insomnia

Avoid caffeine in the afternoon and evening.
Do relaxation techniques.

Upset stomach and/or constipation

Try to drink 6-8 glasses of water a day
Eat more fruits, vegetables and whole grain bread and cereals.

Coughing

Drink water, juice or warm herbal or decaffeinated tea.

Drowsiness or fatigue

Take a walk (get some fresh air).
Do something relaxing or take a nap.

Difficulty concentrating

Reduce stress (exercise or walk)
Manage your time.
Take breaks.

Increased appetite

Drink water.
Eat low-calorie snacks.
Exercise.

Feeling restless

Go for a walk, exercise or do a hobby.

References:

- Morris, Chad D. PhD. , Morris, Cynthia W. PsyD., Martin, Laura F. MD, Lasky, Gina B. PhD Dimensions: Tobacco Free Toolkit for Healthcare Providers, Behavioral Health & Wellness Program , University of Colorado Anschutz Medical Campus School of Medicine.
- Williams, Jill MD Smoking and Schizophrenics 2011, University of Medicine & Dentistry of New Jersey
- CDC Centers for Disease Control and Prevention Vital signs Focusing on People with mental illness February 2013
- Shirley Deethardt, DHHS Tobacco Free Nebraska

QuitNow.ne.gov

Nebraska Tobacco Quitline: 1-800-QUIT-NOW

Medications

List of the most common medication used for tobacco cessation.
Please talk to your doctor before using any medications!

- Nicotine Patch:** Available over the counter
Placed on usually the upper arm.
Duration is 4 weeks at 21 mg
2 weeks at 14 mg'
2 weeks at 7 mg
Side Effects: Local skin irritation, Insomnia
- Nicotine Gum:** Available over the counter
Chew gum 30 seconds than park, repeat for nicotine release
Duration up to 12 weeks
Side Effects: Mouth soreness
- Nicotine Nasal Spray:** Available by prescription only
8-40 doses/day
Duration 3-6 months
Side Effects: Nasal irritation
- Nicotine Inhaler:** Available by prescription only
6-16 cartridges/day
Duration up to six months
Side Effects: Local irritation of mouth and throat
- Nicotine Lozenge:** Available over the counter
2 mg – 4 mg 20 pieces /day
Duration 12 weeks
Side Effects: Local irritation of throat, Hiccups,
Heartburn/Indigestion, Nausea
- Bupropion SR:** Available by prescription only
(Zyban)
150 mg every morning – 3 days
150 mg twice daily (begin treatment 1-2 weeks pre-quit)
Duration: 7-12 weeks, Maintenance up to 6 months
Side Effects: Insomnia, Dry mouth
Precautions: History of seizure or eating disorder or use of MAO
inhibitors in past 14 days.
- Varenicline**
(Chantix) Available by prescription only
0.5 mg once daily for 5-7 days before quit date
0.5 mg twice daily for days 1-4 before quit date
1 mg twice daily starting on quit date
Duration 3 months, maintenance up to 6 months
Side Effects: Nausea, Trouble sleeping
Precautions: Monitor for changes in mood, behavior, psychiatric
symptoms, and suicidal ideation.

References:

- Morris, Chad D. PhD. , Morris, Cynthia W. PsyD., Martin, Laura F. MD, Lasky, Gina B. PhD
Dimensions: Tobacco Free Toolkit for Healthcare Providers, Behavioral Health & Wellness
Program , University of Colorado Anschutz Medical Campus School of Medicine.
- Williams, Jill MD Smoking and Schizophrenics 2011, University of Medicine & Dentistry of New
Jersey
- CDC Centers for Disease Control and Prevention Vital signs Focusing on People with mental
Illness February 2013
- Shirley Deethardt, DHHS Tobacco Free Nebraska

Other ways to stay active

You might have a lot of pent-up energy while trying to quit and stay tobacco-free. Consider these activities when you're looking for something to do besides smoking. Many of these things can help keep you from gaining weight after quitting, too.

Many of these activities are free. Others are fairly cheap. You can rent a DVD for beginner's yoga, tai chi, or aerobics – or maybe even borrow one from the library. You can do some of the exercises at home. Or you can always make up your own activities – this is just a starter list of ideas. You will notice over time that it gets easier to do these things. And watch how much better you can breathe as each day passes without smoking.

Sports

- Walking or jogging
- Biking
- Skating
- Hiking
- Swimming
- Aerobics
- Dancing
- Bowling
- Soccer
- Tennis
- Volleyball
- Softball
- Basketball
- Martial arts
- Yoga

Working around your home

- Gardening and yard work
- Cooking, grilling, or baking
- Organizing/cleaning out the basement, garage, closet, or attic
- Organizing a yard sale
- Painting/re-decorating rooms
- Washing/waxing the car
- Vacuuming and dusting
- Walking the dog (yours or a friend's)

Going out

- Fishing, hunting, or camping
- Having a picnic
- Shopping
- Getting a manicure or pedicure
- Going to a garage sale or yard sale
- Going to a library or bookstore
- Going to a museum
- Going to a movie

Hobbies and crafts

- Playing (or learning) a musical instrument
- Starting a collection (stamps, coins, or shells, for example)
- Puzzles (crossword or jigsaw)
- Board games with family or friends
- Starting a journal or scrapbook
- Organizing photos
- Woodwork, whittling
- Knitting, crocheting, sewing, or other needlework
- Writing (journaling, letters to the editor, poems, articles, or books)

Relaxing

- Reading
- Meditating
- Listening to a relaxation CD
- Taking a nap
- Listening to music
- Catching up on emails

Being with others

- Calling an old friend
- Having someone over for dinner or to watch movies
- Going out to eat
- Joining a group or club
- Having a family get-together

References:

- Morris, Chad D. PhD. , Morris, Cynthia W. PsyD., Martin, Laura F. MD, Lasky, Gina B. PhD Dimensions: Tobacco Free Toolkit for Healthcare Providers, Behavioral Health & Wellness Program , University of Colorado Anschutz Medical Campus School of Medicine.
- Williams, Jill MD Smoking and Schizophrenics 2011, University of Medicine & Dentistry of New Jersey
- CDC Centers for Disease Control and Prevention Vital signs Focusing on People with mental illness February 2013
- Shirley Deethardt, DHHS Tobacco Free Nebraska

Stages of Change- Shirley Deethardt, Tobacco Free Nebraska and Carol Coussons de Reyes, Office of Consumer Affairs, DBH - DHHS Nebraska

SCENARIOS-

PRECONTEMPLATION- I'm not ready...

Scenario #1

Billy Jo is smoking in her house and has a roommate. The roommate is starting to cough from the second hand smoke and asks Billy Jo to quit. Billy Jo says she is sorry, but she can't quit and won't. Billy Jo states it is her right to smoke in her house.

Scenario #2

Tom is at his peer support provider with a deep bad cough. The peer supporter asks, "Have you quit smoking?" Tom says, no and I don't intend to because I like smoking.

The peer support provider can educate and say for the state of your health you may want to consider.

How would you respond to Billy Jo and to Tom

CONTEMPLATION- I'm thinking about it

Scenario #1

Rose is having trouble climbing the stairs, because she loses her breath along the way. She still is enjoying smoking with her friends. She knows she needs to quit one day to keep herself from becoming a statistic, but she's just not ready to quit yet.

Scenario #2

Charles is a two pack a day smoker and he just met a girlfriend that doesn't smoke. He knows he needs to quit and wants to be able to, but he's not ready to commit to quitting. He tells you that his new girlfriend has asked him to quit.

How would you respond to Rose and Charles?

PREPARATION- I want to quit, so now what?

Scenario # 1

Joan has talked to her peer support specialist about her desire to quit soon. She said her family has asked her to quit and she knows it is not healthy. She wants to know what she should do.

Scenario #2

Mark has been advised by his peer support specialist that in order for him to really get healthy he is going to have to leave cigarettes behind. He wants to try to quit, but he doesn't know how to get started.

How would you respond to Joan and Mark?

ACTION- I want to quit now.

Scenario #1

Lee wants to quit smoking, but he's not sure it's the right time because he is has been very sad lately and crying a lot.

Scenario #2

Rebecca desires to quit using tobacco, but she is concerned that the withdrawal symptoms will be more than she can handle. She is afraid she will start smoking again right away.

How would you respond to Lee and Rebecca?

MAINTENANCE- have quit, may or may not be tempted to start again.

Scenario #1

Tobias has quit for 3 months and he is now able to be around his friends in the smoking circle at his behavioral health center. His friend asks him if he is ever tempted to smoke with him again.

Scenario #2

Maria has quit for 2 years and still has cravings when she is around second hand smoke.

How would you respond to Tobias and Maria?

What about Slips and Relapse?

A slip means you smoked after your quit date.

A slip does not mean you have gone back to smoking full time.

If you slip, don't give up!

The best thing to do is to get back on track.

Revisit your reasons for quitting.

Acknowledge you slipped, but stick to your quit plan. A slip doesn't mean you failed!

Get rid of any cigarettes or tobacco you bought.

Think about what led to the slip.

Plan a new way of handling the trigger that led to the slip.

Things to do to avoid slips and relapse.

When you feel a craving for a cigarette, keep busy!

Call a friend.

Chew a vegetable stick, celery or carrot sticks.

Drink a glass of water.

Do relaxation exercises, such as deep breathing.

Go for a walk.

Keep your hands busy, draw or knit or do a puzzle.

Exercise.

Chew sugarless gum.

Brush your teeth.

Clean, wash dishes or iron.

Remind yourself of the reasons you are quitting.

References:

- Morris, Chad D. PhD. , Morris, Cynthia W. PsyD., Martin, Laura F. MD, Lasky, Gina B. PhD Dimensions: Tobacco Free Toolkit for Healthcare Providers, Behavioral Health & Wellness Program , University of Colorado Anschutz Medical Campus School of Medicine.
- Williams, Jill MD Smoking and Schizophrenics 2011, University of Medicine & Dentistry of New Jersey
- CDC Centers for Disease Control and Prevention Vital signs Focusing on People with mental illness February 2013
- Shirley Deethardt, DHHS Tobacco Free Nebraska

When smokers quit – what are the benefits over time?

20 minutes after quitting

Your heart rate and blood pressure drop.

12 hours after quitting

The carbon monoxide level in your blood drops to normal.

2 weeks to 3 months after quitting

Your circulation improves and your lung function increases.

1 to 9 months after quitting

Coughing and shortness of breath decrease; cilia (tiny hair-like structures that move mucus out of the lungs) start to regain normal function in the lungs, increasing the ability to handle mucus, clean the lungs, and reduce the risk of infection.

1 year after quitting

The excess risk of coronary heart disease is half that of a continuing smoker's.

5 years after quitting

Risk of cancer of the mouth, throat, esophagus, and bladder are cut in half. Cervical cancer risk falls to that of a non-smoker. Stroke risk can fall to that of a non-smoker after 2-5 years.

10 years after quitting

The risk of dying from lung cancer is about half that of a person who is still smoking. The risk of cancer of the larynx (voice box) and pancreas decreases.

15 years after quitting

The risk of coronary heart disease is that of a non-smoker's.

These are just a few of the benefits of quitting smoking for good. Quitting smoking lowers the risk of diabetes, lets blood vessels work better, and helps the heart and lungs. Quitting while you are younger will reduce your health risks more, but quitting at any age can give back years of life that would be lost by continuing to smoke.

References:

- Morris, Chad D. PhD. , Morris, Cynthia W. PsyD., Martin, Laura F. MD, Lasky, Gina B. PhD Dimensions: Tobacco Free Toolkit for Healthcare Providers, Behavioral Health & Wellness Program , University of Colorado Anschutz Medical Campus School of Medicine.
- Williams, Jill MD Smoking and Schizophrenics 2011, University of Medicine & Dentistry of New Jersey
- CDC Centers for Disease Control and Prevention Vital signs Focusing on People with mental illness February 2013
- Shirley Deethardt, DHHS Tobacco Free Nebraska

Words of Encouragement: Stages of Change- Shirley Deethardt, Tobacco Free Nebraska and Carol Coussons de Reyes, Office of Consumer Affairs, DBH- DHHS Nebraska

Pre-contemplation

I know you are not thinking about quitting tobacco right now, but you might consider your health an important issue in the near future.

I hear you saying that you are not ready to quit using tobacco, but I want you to know that I am here to help you when you are ready.

I am aware that your family is on you to quit tobacco, but just know they are concerned for your health.

Contemplation

I know quitting is very hard, but with proper support from your health care providers, your family and friends and proper quit plans and follow-ups, it'll be a lot easier on you.

I am very pleased that you are beginning to think that smoking is not good for your health.

Good for you for considering quitting tobacco! Just know that I am here to help with support when you decide to quit.

You might call the Nebraska Tobacco Quitline for support with making that quitting tobacco decision. Quitting can be very difficult but I am so pleased that you are considering quitting tobacco within the next few months.

Preparation

Congratulations on your decision!

Let's call the quit line and get you the support you need in the upcoming months!

You are making a great choice for your overall health.

What new activities are you going to engage in to support your new lifestyle?

What can I do to support you?

What will you plan to do when you pass people that are smoking? What will you be telling yourself?

Action

This decision makes so much sense in your life, what a great way to affirm your life.

I am so proud of your decision.

Smoke free living is going to look so good on you!

Think of all the money you are going to save and the new possibilities!

How can I support you? Will you call me and let me know how you are doing?

Have you called the quit line for support with the action of quitting, they say the beginning is the toughest part?

I have complete faith in you.

Maintenance

Have you had any cravings? What are you doing that is working during these cravings?

What can I do to support your success?

When is your smoke free living anniversary? Let's celebrate in a new way!

A Peer Support Provider on their Duties

"I'm a Peer Support Specialist in the Mental Health Department. As a trained and Certified Peer Support Specialist, my lived experience with emotional and psychological pain allows me to assist others with similar difficulties and challenges by promoting and modeling wellness and recovery."

My goal is to promote self-determination, personal responsibility and empowerment and assist others in regaining control over their own lives and over their own recovery process.

I support and encourage each Veteran to see themselves through their capabilities not their limitations, to embrace themselves as they are and celebrate all they long to be, and to find their own unique pathway to recovery based on their individual unique strengths, needs and experiences."

Veteran's Reactions to Peer Support

"It helps that you as a peer support specialist understand where I'm coming from."

"Thanks for listening to me as a peer."

"You've been a patient on the inpatient unit, like most of us, and now you're working full-time. That really inspires me."

"I'm glad that this group is being led by someone who knows where I have been."

Mental Health Providers on Peer Support Services

"The peer-to-peer model is an exceptional example of the innovative ways in which we can help the system overcome its own barriers. Peer-support programs are not just empowerment programs. They are an expression...and an example...of the way the system is going to have to fundamentally change to foster healing relationships, and create an environment conducive for recovery." Kathryn Power, M.Ed.

"There are things a peer supporter can do that no one else on the team can. There is just no substitute for lived experience of mental illness, particularly in someone trained to share it in a helpful way.

In addition to the unique ability to engage Veterans into the recovery process and numerous other direct benefits to the Veterans, I have found the peer support specialist to also have a transformative effect on other team members. Our peer supporter has truly helped to transform our team culture and make our effort to support the recovery journey of Veterans more authentic. She has personally taught me more about recovery than anyone."

Dan Bradford, MD, MPH, Durham VAMC

"...In my experience peer counselors understand the recovery process at its basic level as they live recovery every day." Julie A. Feely, LCSW



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- Kathleen Dohoney, Psy.D, CRRP, Clinical Psychologist, Dallas VA Medical Center
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- Susan B. George, Visual Information Specialist, Medical Media, Syracuse VA Medical Center

J-Handout

Understanding Peer Support Services in Veterans Health Administration (VHA)



What is Peer Support?

Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful; it is a process dedicated to promoting empowerment and self-determination in the service of recovery.

What is a Peer Support Provider in a mental health setting?

A person with a mental health and /or co-occurring disorder, **who has been trained** to help others with these disorders identify and achieve specific life and recovery goals. A peer support provider is a person **who is actively engaged in his/her own recovery**. A peer support provider is a person **who volunteers or is hired** to provide peer support services to others engaged in mental health treatment.

What is the purpose of a Peer Support Program?

- ◆ To provide opportunities for Veterans to take control of their own recovery.
- ◆ To teach and support the learning of skills needed to facilitate one's recovery.
- ◆ To make Veterans aware of available services and choices.
- ◆ To help Veterans develop a sense of wellness and self-worth.
- ◆ To bring a unique perspective to the treatment teams on which they work.

What do trained Peer Support Providers do?

They serve as role models by sharing their personal recovery stories, showing that recovery from mental illness is possible.

They teach goal setting, problem solving, symptom management skills and a variety of recovery tools.

They empower by helping others identify their strengths, supports, resources and skills.

They advocate by working to eliminate the stigma of mental illness.

They act as community liaisons by identifying social supports in the community and encouraging the expansion of local community resources.

Advantages to Peer Support

Studies have demonstrated the positive impact peer support makes to the recovery of people with serious mental health conditions:

- ◆ Improves social functioning and quality of life
- ◆ Lessens the sense of loneliness, rejection, and discrimination
- ◆ Fosters independence
- ◆ Improves ability to deal with mental illness
- ◆ Increases access to resources beyond the VA
- ◆ Improves skills necessary to recover
- ◆ Improves communication with providers
- ◆ Improves employment outcomes
- ◆ Provides comfort and support
- ◆ Fewer hospitalizations
- ◆ Use fewer crisis services
- ◆ Improves the effectiveness of the mental health delivery system

Myths and Misperceptions of Peer Support

"The Peer Support Provider would have difficulty with all the paperwork and not able to handle the stress and demands of the job."

Stress is a very individual response to specific situations. It is not true that people with mental illness cannot handle stress. Stigma persists among many mental health providers who continue to believe that recovery is not possible for consumers.

"Since Peer Support Providers are not licensed independent professionals, who will be responsible when something bad happens?"

Peer Support Providers must complete VACO approved training and pass a rigorous competency assessment to perform their peer support role, including crisis management. Peer Support Providers are similar to addiction therapists or other non-licensed providers.

"The Peer Support Provider is not aware of professional boundaries."

Peer Support Providers are provided formal guidelines and supervision governing client/staff boundaries and explicit policies and practices that determines how information is shared.

"Client records should not be shared with Peer Support Providers because they cannot maintain confidentiality."

Peer Support Providers are provided the same orientation as non-peer staff and are held accountable to the same policies and procedures to manage and control the disclosure of information.

How do you talk to a veteran?

Talk to ME.

Joel Schneider, CPS
Norman McCormack, MS, MPA
Returning Veterans Resource Network
Omaha, NE

RVRN

1

Who is a Veteran?

- Dad
- Mom
- Sister
- Brother
- Aunt
- Uncle
- Cousin
- Anyone

RVRN

2

What Defines a Veteran

Service
Pride
Patriotism
Perseverance
Humility

RVRN

3

**Who am I?
Who am I FIRST?**

- Dad • Aunt
- Mom • Uncle
- Sister • Cousin
- Brother • Friend

A PERSON FIRST

RVRN

Where Do I Fit In?

With My Family
Where I Work
Where I Play
In My Community
Back Where I Started Life

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How to Talk to Me?

As you would to anyone else.
I am a person first
A veteran second

Being a veteran is **part** of who I am
It does not **DEFINE** who I am

RVRN

First Contact Questions

- Thank you for your Service.
- What branch were you in?
- What was your job (MOS, AFSC, Rating)?
- Where are you from? (PERSON FIRST)
- Where did you serve?
- I heard it's really hot there.
- Are the people friendly?

If your friend went to Paris, what would you ask?

RVRN

7

Questions you might want to avoid - Use Common Sense -

- Did you kill anyone? / How many?
- Did you lose any friends?
- How many tours? / How long in combat?
(Its like telling someone you were in a train wreck and they ask: "How long of a train ride was it?")

The tough answers will come on their own terms

- voluntary ~ don't push -

RVRN

8

- SOMETIMES IT'S HARD -

But sometimes it's hard for everyone

Be available

Don't be intrusive

Ask me what you want to know,
but if I say: "I don't want to talk about it."

Ask Me Later

RVRN

9

Explaining the Inexplicable

Some things just don't make sense

~ ~ ~ ~ ~

I can't explain to you what
I can't explain to myself

RVRN

10

**Love Me
Allow Me to Love You**

There are **burdens** that can be **only** mine

I don't want our Love poisoned by my burdens

ASK AGAIN LATER
I will share with you **if** I can

RVRN

11

What I Need / Want

- Respect
- Acknowledgement
- Acceptance
- A decent job
- A good home
- A family
- A Fair Shake**

WHAT WE ALL NEED AND WANT

RVRN

12

Feelings Aren't Easy

The military taught to me to **hide** my feelings
Acknowledging emotion requires mental energy
“Wasting” energy on feelings made us **vulnerable**
Even now, feelings **scare** me
Anger is my way of **running** from emotion
And... from you
Listen – if you can
Help me recognize, channel, and direct what I feel

RVRN

13

Adapt – Improvise – Overcome Change based on the tactical situation

- FRAG Order
- **F** – feelings: explore where they are coming from and what they mean
- **R** – reality: what you perceive and what is real may be different
- **A** – assess: explore all options, scan your environment - don't get tunnel vision
- **G** – get some: make a new plan – set some realistic goals – GO FOR IT

RVRN

14

ASK FOR HELP

(It Works – REALLY)

First Line of Defense = **TALK ABOUT IT**
Everything sounds different when said out loud
Think outside the box – explore other options
You are your own best **advocate**
Change, Hope, and Recovery do exist and are possible
GET HELP
THEN REACH OUT TO HELP ANOTHER
You know you made a difference in life when one of your students becomes one of your teachers.

RVRN

15

**RETURNING VETERANS
RESOURCE NETWORK**

A Community-Based Peer Support Group
For Veterans and Their Families
(Non-Affiliated - Non-Governmental)

Open Meeting Every Monday Night at 6:00 PM
40 & 8 - Vets club, downstairs. 3113 So. 70th St.
(70th & Spring Street)
Omaha, NE 68106

(402) 734-1774



omahavetnet.org

RYRN

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