The Center for Disability Rights, Law and Advocacy

Nebraska Advocacy Services, Inc.

Peer Advocacy Task Force

Initial Study Report:
Developing a Peer Advocacy Program Model for Nebraska

2003

DISCUSSION DRAFT

This publication was made possible by funding support from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. These contents are solely the responsibility of the grantee and do not necessarily represent the official views of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

TABLE OF CONTENTS

Introduction

For fiscal year 2002, one of the work objectives of Nebraska Advocacy Services was to coordinate a task force to study and initiate development of a model program for external peer advocacy in the three state mental health regional centers. In May 2002, Nebraska Advocacy Services convened a twelve-person task force to begin this investigation. To achieve inclusive and balanced program development and study, Nebraska Advocacy Services solicited task force members from a variety of perspectives, including mental health professionals, consumers, and state officials. A list of task force members is attached in Appendix A. The task force met monthly from August 2002 until December 2002.

To facilitate a focused discussion, the task force identified six major issue areas they believed were fundamental to an effective peer advocacy program: confidentiality, funding, training and education, activities and function of peer advocates, liability and other legal issues, and outcome measurements for program evaluation. This list is not meant to be exhaustive as there are other important aspects of program development that need to be addressed, but it was beyond the scope of this task force to investigate every issue. Rather, the task force believed that the six issue areas they identified and prioritized, along with the task force's recommendations, would provide a good starting point for further discussion.

The task force was strongly committed to the idea of peer advocacy. Consumers can provide shared experience and first-hand knowledge that is essential to developing an effective peer relationship. The task force strongly believed that in order to be effective, peer advocates must be independent of the mental health providers in order to ensure frank discussions about an individual's treatment regimen, plan, and activities.

After an initial introduction to and a robust discussion of peer advocacy concepts, the task force decided to focus on six existing peer advocacy programs: the Peer Supports Program in Georgia; the Peer Specialist Program in Colorado; Peer Bridgers in New York; The PEER Center in Florida; Vermont Liberation Organization Peer Advocacy Project; and the Protection and Advocacy, Inc. Peer Advocacy Program in California. These programs were selected because they had priorities and principles similar to the task force's. A comparison of these programs according to the six issues identified by the task force is included as Appendix B. The task force believed that experiences of these programs would be most helpful in guiding and fashioning a unique program for Nebraska. After extensive discussions about these six other programs, the task force concluded that the New York "Peer Bridger" program would be the most suitable model.

Issue Area 1: Confidentiality

All of the models the task force examined noted the importance of confidentiality in peer advocacy. This underlying confidence between advocate and client is at the heart of the peer advocate relationship.

The California model states, "Clients need someone they can talk to in confidence. We honor the confidentiality of our clients and only share things with their permission." Peer advocates in Colorado, for instance, are only to report matters when the client is a danger to him/herself or others. It is common for confidentiality to be addressed in peer advocate training. Some of the models the task force studied require staff to sign confidentiality statements upon hire; some also set forth guidelines for limited access to consumer records. The task force believed that peer advocates should sign confidentiality statements and a code of ethics should be created for peer advocates that reinforces the importance of confidentiality.

Although the task force felt that confidentiality should be included in the design and procedure of a Nebraska peer advocacy program, they identified three additional questions would need to be addressed:

- Would participants need to sign release statements?
- Would release statements be adequate?
- Would advocates be allowed to participate in treatment meetings without a release statement?

Issue Area 2: Funding

The majority of peer advocacy program models the task force looked into were primarily funded by state government.

In light of Nebraska's current budgetary difficulties, the task force recommended that a peer advocacy pilot project should be developed for either the regional centers or community health centers utilizing private funds (and perhaps limited state funds). The task force considered the possibility of expanding the Peer Advocate activities at the Norfolk regional center. The task force identified a variety of potential funding sources for this project:

- Americorps
- VISTA
- Health and Human Services (Medicaid)
- Woods Charitable Trust and other philanthropical foundations
- Community Health Endowment
- Magellan
- Pharmaceutical companies
- Community mental health centers
- Hospitals and service providers
- Nebraska Psychiatric Association
- Regional centers (may be in-kind)
- Community health education funds
- Center for Mental Health Services block grant
- Federal Center for Mental Health Services funding
- Local health departments
- Community foundations in Nebraska
- Collaboration with existing projects
- Corrections system

Issue Area 3: Training and Education

A critical aspect of any peer advocacy program is the training provided to the peer advocates. All of the models considered by the Task Force included some level of training for peer advocates. The depth, intensity, and nature of the models' training modules naturally vary somewhat, since each model considered by the task force operated within its own organizational priorities and its own state's laws. The task force noted that a training module unique to Nebraska's laws and needs must be developed since training and education play such important parts in achieving program success. Although the task force concluded that the intricacies and specific information to be included in a training module should be developed in the future, they identified a number of concepts that can guide subsequent development of a training regimen. The task force noted that peer advocates should receive formalized training and education regarding advocacy resources and crisis planning, as well as the procedural and organizational operation(s) of pertinent governmental agencies and systems. Given that the primary nature of the peer advocacy is relationship building, assisting in treatment and post-discharge planning, and easing community re-integration, peer advocates must be knowledgeable about the resources available to achieve these ends, and where and how to obtain them. Peer advocates must also have an understanding of basic techniques to deal with personal and relationship crises that may occur. If peer advocates are unprepared to handle crises, they will not be as effective in developing the sense of trust that is essential to successful peer advocacy relationships. However, the task force was very clear about the nature of such training: it should not be designed to minimize the consumer-driven and consumer-directed aspect of the program. The task force also concluded that peer

advocate training and education should not be limited to a peer advocate's initial introduction to the program. Rather, training and educating peer advocates must be maintained on an on-going basis, with the frequency to be determined with subsequent content development.

In addition to training and educating peer advocates, the task force identified the need for external program education and training. Initially, the task force agreed that a high priority should be placed on training and educating the program's advisory board and program administrators regarding program philosophy and mission. To this end, the task force concluded that the immersion training offered by the Peer Bridgers program in New York would be necessary.

The task force also noted that if Nebraska's peer advocacy program is to be successful, the program must maintain linkages with other systemic organizations, agencies, and resources. For example, third parties must be educated about the program's existence, mission, and operation. Cooperation and interaction with these third parties will help the peer advocacy program survive—most importantly they will provide the referrals and opportunities for the program to provide peer advocacy services. The education must not be limited to making others aware of the program but also encompass increasing awareness of the program's approach and philosophy. The task force identified a list of such third parties, including:

- Legislators and policymakers
- Treatment teams and providers
- Consumers
- Family members
- Advocacy organizations
- Law enforcement/Clergy
- Emerging professionals
- External funding sources
- Media

Issue Area 4: Activities and Function

The specific activities and functions of peer advocates, it was decided, would be left to future programmatic discussions. However, there was wide agreement that since the overall purpose of the Nebraska peer advocacy model was to build trusting relationships to enhance treatment/post-discharge planning and community re-integration. These activities would be a program focus—much like the Peer Bridgers program in New York. Since the Peer Bridgers program incorporates much of the identified philosophy and approach that the task force desired for the Nebraska program, it was decided to postpone decisions on what specific activities and how those activities would be performed until after discussions with Peer Bridgers officials were concluded. The intent is to take lessons learned from the Peer Bridgers program and combine/adjust those experiences with ideas from Nebraska stakeholders.

Additionally, the task force proposed some areas to begin thinking about how the program will operate and where peer advocate relationships should be initiated:

- when Emergency Protective Custody happens
- during initial admittance to a regional center
- how many relationships an individual peer advocate should have
- peer advocates must be paid (this would provide an incentive for consumers to act as peer advocates, and compensation provides a mechanism for consumers to create and maintain financial independence)
- work scheduling must be flexible and medical benefits must be provided to peer advocates

While leaving the specifics to future meetings, the task force agreed that peer advocate inclusion in treatment teams was essential.

Issue Area 5: Liability and Legal Issues

The models reviewed by the task force reported few problems in the area of potential liability because of peer advocacy activities. It should be noted that the role of peer advocates is advocating for the patient when patient rights are not being honored.

It is expected that advocates may be more likely to report violations of patient rights at treatment meetings than the individual receiving treatment. It is important not to confuse these reports with potential liability to the institution. The comments of advocates at treatment meetings should be given appropriate attention and steps need to be taken to act on issues they raise. It seems entirely possible that an alert advocate may be able to raise a red flag when a particular client's situation is showing warning signs of potential abuse, allowing the institution to handle this situation effectively before actual abuse occurs.

Issue Area 6: Outcomes

The final program aspect the task force felt must be included in the Nebraska model was outcomes. The task force agreed that establishing measurable outcomes, or benchmarks, was vital to maintaining a successful peer advocacy program. Outcomes would primarily serve two purposes: to gauge program effectiveness, and to provide concrete data to use when either explaining the program benefits to external parties (such as legislators) and potential funding sources. However, the academic literature on peer advocacy programs, let alone peer advocacy program outcomes, is very limited. The model programs studied by the task force included some form of outcome assessment, but few had fashioned tools that would create quantifiable data. The task force agreed that some level of outcome assessment must be quantifiable. Discussion on assessment

tools and techniques highlighted the complexity of the issue: many of the goals and objectives of the peer advocacy program (e.g., relationship building, quality of life issues, and community integration) do not easily lend themselves to quantitative data assessment. However, the task force agreed that there were some core outcomes that could be assessed quantitatively:

- Rate of in-patient hospitalization pre- and post-program
- Length of stay (hospital, institution, or incarceration) for program participants
- Amount of time between "discharge ready" and actual discharge
- Various demographic data
- Rate of re-institutionalization
- Employment
- Number of persons living independently post-program and for how long

To complement the quantitative assessment, some qualitative data must also be collected. Such measures would attempt to assess quality of life issues. Given the inherent difficulty in assessing this type of data, the task force suggested that more research and analysis of other qualitative research approaches be conducted before making decisions on specific evaluation tools.

The task force suggested the following characteristics for a framework to guide discussion on what form future outcome assessment tools should take:

- The evaluation methods/tools used need to reflect the context of the relationship initiation, e.g., relationship initiated post-discharge, relationship initiated two days into treatment regimen.
- The evaluation tool must be consistent with other stakeholders' data collection tracking categories for consistent and unbiased comparison
- The data evaluation and storage must be sensitive to, and respect, privacy
- Evaluation measures must be least-intrusive

Appendix A: Participant List

NAME	TITLE	EMAIL ADDRESS
Ann Bartlett	President, NAMI-Nebraska	ab11721@alltel.net
Barbara Ramsey	Director, Lincoln Regional Center	barbara.ramsey@hhss.state.ne.us
Bob Dericks	MHA-Nebraska Board member	rrdericks@aol.com
Brad Meurrens	Public Policy Specialist, NAS	brad@nas-pa.org
Bruce Riedman	MHA-Nebraska Board member	jbriedman@msn.com
Cheryl Carnazzo	Member, NAMI-Omaha	tanzin64@hotmail.com
Cheryl Crouse	Peer Specialist, Goodwill Inc.	peersupport@goodwillne.org
Cindy Scott	MHA-Nebraska Board member	hs35558@alltel.net
Dan Powers	Peer Specialist, DHHS Behavioral Health	dan.powers@hhss.state.ne.us
Deanna Parker	Support Staff, NAS	deanna@nas-pa.org
Eric Evans	Deputy Director, NAS	eric@nas-pa.org
George Hanigan	Deputy Director, DHHSS Behavioral Health	george.hanigan@hhss.state.ne.us
John Holzhey	NAMI-Omaha	jholzhey@cox.net
John O'Neal	Consultant, NAS	johnonealii@cox.net
Kellie Moyer	PAIMI Program Coordinator, NAS	kellie@nas-pa.org
Linda Sparr	Peer Specialist, Norfolk Regional Center	linda.sparr@hhss.state.ne.us
Mary Angus	NAMI-Omaha	maryangus2@msn.com
Mike Oliverius	Vice President, NAMI-Nebraska	moliverius@neb.rr.com
Molly Klocksin	Case Advocate, NAS	molly@nas-pa.org
Richard Gamel	Director, Norfolk Regional Center	richard.gamel@hhss.state.ne.us
Sam Kaplan	Attorney, DHHS	sam.kaplan@hhss.state.ne.us
William Gibson	Director, Hastings Regional Center	william.gibson@hhss.state.ne.us

Appendix B: Models Studied

State	Confidentiality	Funding	Training
Georgia	Covered in consumer supports certification training.		State certification of Certified Peer Specialist overseen by Office of Consumer Relations. Training for certification is standardized and includes: 1. continuing education 2. ethics 3. confidentiality 4. forms and medical documentation
Colorado	There is complete confidentiality between the peer specialist and the consumer. The only time anything would be reported is when someone is a danger to him/herself or others.	Funding through contract between Behavior Health, Inc. (state's managed care company) and Community Connections (consumer-run drop-in center). Peer Specialists paid at hourly rate, most work part-time, and on-call. Scheduling is consumer-driven.	Peer Specialists complete 8-week training course with intensive training in: charting, confidentiality, relationship building, attending skills, learning to respond, follow-up skills, and the treatment plan. On-going support provided by weekly team meetings, and daily personal contact with peer specialist trainers.
New York	Staff sign statement upon hire.	State funded. In 1994, New York State Office of Mental Health approved funding for New York Association of Psychiatric Rehabilitation Services (NYAPRS) to implement a demonstration project to assess peer support services to ease community transition for individuals with long or repeated state hospital stays. Funding was increased in 1996.	Peer Advocates/Specialists are consumers and must undergo Peer Bridger training.
Florida	Has not been an issue. Staff is required to sign confidentiality agreement upon hire.	State funding through the Department of Children and Families; Federal funding through SAMHSA grant; and a membership fee ($1.00) collection.	Since the PEER Center is a consumer-run organization, Peer Advocates/Specialists are/have been consumers and receive training in case management. PEER center also holds classes teaching vocational skills (e.g., typing, computer skills, GED preparation); has arrangements with Nova Southeastern University to offer internships with Occupational Therapy students; and maintains a library for members.
Vermont	"Initially, only Regional Coordinators and the Project Director will be given authority to examine records…	To be provided by Vermont Liberation Organization (non-profit organization).	Three Regional Advocacy Coordinators responsible for training.
California	"Clients need someone they can talk to in confidence. We honor the confidentiality of our clients and only share things with their permission."	Under a contract from Protection and Advocacy, Inc. (PAI) CNMHC launched a client-run training program for peer advocacy, the Peer and Self-Advocacy (PSA) Program. Public Law 99-319 (the Federal Protection and Advocacy for Mentally Individuals Act of 1986) mandates that each state provide an independent advocacy system for persons labeled "mentally ill". The PSA Program was established to train clients and ex-clients in peer and self-advocacy techniques."	"Office of Patients' Rights; (This function is operated by Protection and Advocacy, Inc., under a contract with the State Department of Mental Health.)" "1. Training for county patients' rights advocates (WIC 5512). WIC 5512 states that the office shall train local county patients' rights advocates …" (p. 11)

State/Model	Specific Activities/Function	Liability/Legal Issues	Outcomes
Georgia	Services delivered include: • starting and sustaining mutual support groups • wellness recovery action plan and goal setting • problem solving and self-advocacy • consumer rights • symptom reduction		• Partnership with University of Georgia to evaluation outcomes • Liaison with Dr. Jean Campbell to utilize peer support evaluation tool
Colorado	Act as peer counselors and as peer advocates/mentors. Peer Specialists carry a beeper or cell phone and can be called day or night. They meet with consumers in public whenever need be.	Peer Specialists are not licensed mental health practitioners. No legal issues have arisen. Specialists are to contact the LMHP or appropriate emergency personnel in extreme situations.	The program goals include reducing hospital days and improving quality of life.
New York	**Relationship building:** The purpose of the Peer Bridger program is to provide assistance to persons in state psychiatric hospitals pre-and post-discharge. A key part of this assistance is developing a trusting relationship between the advocate and the consumer. Relationship roles include: role model, mentor, teacher, advocate, supporter, ally, and a source of encouragement. Relationships are intensified per a specified model. **Peer support meetings:** held weekly at designated psychiatric centers, and serve both to give residents a safe forum for encouragement and recovery, and recruit interested consumers. **Discharge Planning:** The goal of the program is to provide hospital residents with a peer bridger match for intensive personal support services in preparation for discharge and during the initial adjustment/transition to community living. Typically, this match lasts about 12 months, but can be adjusted per request and needs of the resident.	No policies out of the ordinary.	Outcomes and program evaluation have been performed through surveys and demographic data collection in 1996 and 1998 specifically. Variables included in the evaluations included, re-hospitalization rates, disorder characteristics/numbers, symptom management, recipients' perceptions of the program regarding enhancing recovery, gender, ethnicity, type of disability (e.g., co-occurring substance abuse or physical disability combined with mental illness). Very positive results have been reported.

State	Specific Activities/Function	Liability/Legal Issues	Outcomes
Vermont	"The peer advocacy system described in this proposal is based on the principle that whenever possible, people should be empowered to advocate for themselves and their peers."	The three regional coordinators, assisted by the State Director, are responsible for the investigation and resolution of complaints. Issues that they cannot resolve will be referred for legal action. VLO has worked with Legal Aid and the ACLU on lawsuits.	"…to disseminate information about rights and entitlements, to identify and investigate instances of abuse/neglect or rights violations, to seek administrative remedies, and to facilitate access to legal services in those situations which do not respond to lay advocacy."
California	Act as advocates for clients and train clients in self-advocacy. "Local Patients Rights Advocates' primary responsibility is the investigation and resolution of individual problems." (p. 12) "As clients, we are able to develop and offer practical training to clients and former clients. In our trainings, we use language we understand and focus on issues which we know are important to clients because we've been there ourselves." (p. 8)	The following are the other assigned duties of the Office of Patients' Rights: Be responsible … for implementing patients' rights laws and for resolving complaints alleging violations of patients rights." (p. 12)	"The program's goals are: to inform clients of their rights; to train clients to exercise their rights, to get what they need and to protect themselves from abuse and neglect in the mental health system; to help clients become more able to negotiate the maze of bureaucracy and ultimately become their own best advocates." (p. 7)
Florida	**Sheltered Employment**: PEER Center operates a public, in-house printing center called Peer Print. Through working in Peer Print members receive vocational skills training. PEER Center also operates a thrift store where members receive retail and inventory experience. **Peer support groups**: Various support groups are facilitated by either members or staff. Examples include: Dual Diagnosis, Depression, Anger Management, Narcotics and Alcoholics Anonymous, Panic Disorder, Art Therapy, and Schizophrenics Anonymous **Drop-in Center**: The PEER Center Drop-In Center is open seven days a week and offers a place of respite, where members can come to meet and participate in social and community activities, group meetings, watch movies or learn how to use state-of-the-art computers to surf the Internet. The Drop-in-Center activities are planned by a committee of PEER Center members (Activities Committee). **Crisis Intervention**: Trained professionals provide case management and counseling to those members experiencing a crisis or in turmoil. Referrals to community mental health centers are made for those who need more intensive services. **Housing Assistance**: Staff provides location and start-up financial support for members to obtain individual, safe, affordable housing in the community. Case management is provided also to help teach independent living skills and environmental stability. **Information and Advocacy**: Members receive referral assistance and information regarding social security, housing issues, state assistance, and other issues consumers raise. Members who encounter problems in the community can seek assistance through the advocacy program. PEER Center recently initiated Project CALM, a jail diversion program	Center has basic insurance. Has not been an issue.	Grant reporting requirements are contracted out. Audit criteria fluctuate somewhat, although availability of service is a key variable.

Appendix C: Program Priorities

Wall Paper minutes from Dec. 17 meeting

Confidentiality

Would participants have to sign release statement? Would that be enough?
Would advocates be able to participate in treatment meetings without a release statement?
Any statements must be global, so one does not have to fill out new documents every time. Peer advocate would not necessarily be required to review medical records.
A code of ethics should be used to reinforce the value and policies of confidentiality.
Supervisors would have access to information at some level.

Specific Activities

Discharge planning is key focus. Where relationships are made is an important variable in program planning. Advocates' inclusion in treatment teams is vital (could be a place to initiate relationships). EPC might be a good time to initiative relationships (more of a long-term focus). Offer information at initial welcome to the regional centers. Activities must be able to be assessed at any time.

How many people does a peer advocate have? How many relationships?

Peer advocates must be paid, flexibility in schedule and benefits are important, especially for consumers.

Location, Funding, and Scope

LRC and NRC are most receptive to program and concepts. Path of least institutional resistance is key for success of program. Lincoln and Norfolk already have support for consumer-driven projects, some projects with this value already in place and could assist the current proposed program of peer advocacy. Those places nearest universities should be top priority given the relative ease of partnering with the university to perform evaluation number crunching.

Scope: Local or Statewide? Project should be narrow in scope to provide good data and evaluation. Narrow scope would also ease data collection. It was agreed that the scope would be localized for now, in order to provide good data for the eventual push for a wider system of peer advocacy. Also those areas where ACT teams are active should be involved in the evaluation methodology.

Funding

A brainstormed list of potential funders:

- Americorps
- VISTA
- HHS (Medicaid)
- Woods Charitable Trust
- Community Health Endowment
- Magellan
- Pharmaceutical companies
- Other foundations
- Community Mental Health Centers
- Hospitals and service providers
- NE Psychiatric society
- Regional Centers (may be in-kind)
- Community health education funds
- CMHS Block Grant
- Federal CMHS funds
- Local Health Departments
- Community foundations throughout the state
- Collaborate with existing projects (e.g. FBO grant)
- Corrections system

Training and Education

People to train and educate:

- Peer Advocates themselves:
    - Initial and on-going
    - Need to know advocacy resources
    - Crisis planning
    - Both "book" training and on-site visits (e.g., immersion training, bring the NY model administrators to Lincoln)
- Legislators and policymakers
- Treatment teams and providers
- Consumers, family members (e.g., NAMI, MHA-Nebraska, other advocacy organizations)
- Law enforcement and Clergy
    - Primarily about crisis management
- Emerging professionals
- Funders
- Public relations and the media

Priority—immersion/*in situ* training for advisory board—and to develop training and recruitment methods/criteria.

The project should reflect on lessons learned from Citizen Advocacy and Leadership Academy programs; would be very instructive and helpful for training/education development.

Outcomes and Evaluation

Measures and outcomes should be easily quantifiable. Some preliminary statistics to include:

- Rate of in-patient hospitalization pre- and post-program
- Length of stay (hospital, institution, or incarceration) for program participants
- Amount of time between "discharge ready" and actual discharge
- Various demographic data

Quality of Life should be assessed. Other organizations and studies have used different measures of quality of life (e.g., "Well-being Project" with Dr. Jean Campbell, Village Integrated Services Agency, Federal Families for Children's Mental Health, and the Peer Bridger program. A consumer satisfaction survey was suggested).

Evaluation tool design characteristics:

- Measures used will depend on where the model starts
- The test population must be homogeneous
- The population for the demonstration project be consistent with other entities' data collection tracking categories for consistent and unbiased comparison
- State data privacy concerns might complication collection methods
- Data collection categories will drive somewhat the decision regarding who gets service
- Measures must be least-intrusive and confidential

Consumers must do and have input as much as possible on the project.

Next Steps

Report writing is targeted to be finalized by Jan. 31, 2003. John, Brad, and Eric will compile the report and disseminate it to task force members and the NAS board. If there is significant controversy or disagreement, a final follow-up call to achieve compromise will be placed.

Appendix D: Sample Program and Job Descriptions

IMPACT OF/REACTIONS TO THE PEER BRIDGER PROJECT

HOW DO RECIPIENTS VIEW THE PEER BRIDGER PROGRAM?

"An Evaluation of the Peer Bridger Initiative" Cheryl MacNeil, Principal Investigator, August 1996

When service recipients were asked if the project helped them in their recovery, 88% of the respondents stated that 'yes', the project has been helpful. One respondent noted it gives you a *"feeling of being in control of your own destiny-it makes me stand on my own two feet"*. Other comments highlighted the empathy bridgers are able to provide, *"talking about recovery with someone who understands me"*, and the sense of having *"freedom of speech"*. One interviewee noted, *"They are just here when you need them - its not like the staff."*

Not only are bridgers able to identify with the recovery process, but stakeholders perceive bridgers to be more sensitive in the way they interact with their matches as compared to other service providers. As one respondent noted, *" It is more of a friendship basis. You don't seem to get the same answers from case managers. They say things like, 'You're suppose to be independent, you can learn it...you can do it'. It's not that easy. You're nervous when you go to a new area. Case managers don't understand how scared you really are. They don't have that behind them."* Another interviewee made a distinction between the Bridger and an advocate, *"Setting up a relationship that is confidential and requires trust is a lot more challenging than advocacy. There are a lot more subtleties involved."*

Service recipients commented that *'attitudes are better'* and *'the bridgers are more open'*. One recipient strongly commented, *"They (bridgers) help you, they don't mind talking to you. They have a decent attitude. Some people here (hospital) treat you like garbage, like you have a disease. The bridger listens and we talk a lot about me...she wouldn't judge me."*

Service recipients perceive the Bridgers as more flexible regarding planning activities. *"I like the peer Bridger, it is not a hassle...if you don't want to do it, they don't do it.."* (Bridgers indicate although there is flexibility in scheduling their hours, schedules often have to be tailored to when they can get access to people in the hospital).

There is a perception among respondents that the Bridger project provides a solution-oriented approach to mental illness as opposed to a problem-oriented one. The project is seen as unique in its reliance on, and dedication to, peer support and recovery. Two respondents summed it up best in stating, *"We do more, you have an opportunity to get yourself out of bed and do something"*, and *"It addresses the issue that medicine, doctors, and psychotherapy are the means to treating mental illness. These methods often discount the benefit of relationships."*

"It's great to have a place to talk freely and not have to worry about what is said."
" The responsibility and accountability I have obtained. They pinpoint the problems and I play my cards and cope."
"It's a good thing...its kept me from drinking and drugging."
" Being able to curb my anger has helped me to stay out of the hospital."
" I made CPU, now I'm on my way out."

"What do you enjoy most about being involved with the Peer Bridger program?

Receiving Help	31%
Getting off the grounds/activities	22%
Social Advantages	22%
Learning	8%
Personal Gratification	8%
Mutual Support	5%

Peer-Bridger Project Program Evaluation Research

Prepared by National Health Data Systems December 1998

Program Satisfaction

Overall, Matches are satisfied with the program:

- 100% would recommend the Peer-Bridger Project to other people in need of services
- 91% want to remain in the Peer-Bridger Project for now
- 91% report that the Peer-Bridger Project is appropriate to their needs
- 82% report satisfaction with the Peer-Bridger Project for the most part
- 82% report that the Peer-Bridger staff are interested in improving their lives

---

Participatory Evaluation of the Peer Bridger Program November 1998

Prepared by Cheryl MacNeil, Ph.D.

"...Participants from the Albany Program component agree that there are several areas where the program has benefitted those involved:

1) The development of uniquely different relationships than one typically experiences in a psychiatric hospital

The opportunity to talk outside of the treatment team and with someone with a 'different bias' from staff was seen as a major benefit of the bridger program. One participant summed it up best in saying, *"The support is great. I talked to my bridger about every problem I had.*

"My bridger didn't say, 'you don't need to feel that way", was a comment offered by one participant when describing the distinctive interaction between people in the hospital and their peer bridgers. It is a unique peer experience. "It isn't a high-up person".

"I can blow off steam and it doesn't matter, it doesn't change the relationship"

2) The temporary relief from a state of social isolation and physical enclosure often experienced by those hospitalized

The bridgers facilitate a temporary break from the seclusion and isolation. People involved in matches report that, in having a chance to be in the community, they are "learning the ropes", "the proper social skills", and "some of life's little lessons". It is reported that bridgers are viewed as a much needed additional resource to access the community, that people involved in matches look forward to their bridger time, and program participants are being encouraged to do more in the community with their bridgers as it will help them get closer to discharge.

"It is an escape from the enclosure."

3) The ability to share with each other the experiential wisdom and survival skills necessary for the process of recovery

People involved in matches give a lot credit to their bridgers for the way in which they help them towards their transition. *"They've been in similar situations and can teach others how they can benefit", "It's easier to talk with [my bridger] because [my bridger's] been in the hospital", and "I think it works no matter what, you make friends, and that part would be strong in the community", are just some of the statements reflecting the positive benefits to this empathetic relationship.*

"[My bridger] helped me stay out of the hospital, helped me through the headaches by talking about my problems".
"My discharge date is still way off but [my bridger] was helpful in getting me toward it".
"[My bridger] helped me learn how to cope...I expect to move on".
"[My bridger] helped me into the group home".
"A month ago [my bridger] started working with me. I got on the list for [the group home]".

HOW DO PROFESSIONALS VIEW THE PEER BRIDGER PROGRAM?

"An Evaluation of the Peer Bridger Initiative" Cheryl MacNeil, Principal Investigator, August 1996

OMH direct care facility staff provided the following comments:

"(This approach) gives the patient contact for people to speak with, they do remember when they speak to the bridgers, whereas sometimes they don't remember others."
"Since their involvement with the program those who have left will come back and talk to others."
"A few patients have moved - their discharges were cemented by the Bridger program."
"(It provides important preparation and) exposure to the discharge."
"They give people a network in the community- they are a social network, much like having a friend."
"There is nothing like picking up the phone and having a friend to call to have a cup of coffee with."
"Consumers who have recovered are an example for people who are still fearful of the process."
"The organization of the groups (provide) an identifiable survivor group."
"(This approach) seems to have more of a recovery aspect to it."
"The program is) getting patients to identify with someone who is a friend in the community."
"(It offers opportunities for) visitation in the hospital and for sharing experiences."
"People ask for the Bridgers, 'Are they coming', and they remember their names... if you ask 'who is their social worker?' they don't remember."
The biggest problem is with) "the small numbers that can be served, people are disappointed when they can't get a bridger."

When asked how the project could be best improved, the largest majority, 48%, of facility staff said it was to "increase services and support."

" There was the development of a beautiful relationship, the Bridger staying with a person through transitions from home, to hospital, to nursing home, to being one of the only persons to attend his funeral."

HOW DO STATE FACILITY ADMINISTRATORS VIEW THE PEER BRIDGER PROGRAM?

"In addition, the inservices that have been made available to staff have supported the concepts of empowerment and recovery." Carol Krizan, Binghamton Psychiatric Center

"..the impact or power of a peer is never to be underestimated. Shared experiences, the sense of understanding and the ability to rely upon someone..are components of what we all need. The Peer Project..is working! More is needed." Rebecca Costa, Pilgrim Psychiatric Center

"You have become an integral part of our (program). This has been a particularly valuable experience for our consumers who do not have privileges to attend programs outside of the building..(and for) consumers who are (typically) not interested in other types of groups and activities. You have reached well over 500 staff..and allowed (them) to understand their roles in our consumers' recovery and to gain a different perspective on illness, treatment and recovery." Patricia Nolan, Creedmoor Psychiatric Center

"I have had the pleasure of working closely with you and your staff..and have always found the relationship professional and reciprocal. (Your) groups provide key information in a safe, benign forum that allows for the beginning of trusting relationships. I am personally aware of positive client testimonials for both the individual peer bridger matches and the groups. We (currently have) a waiting list of approximately 6 clients. Are there any plans to expand the bridger program to enable..more access? Henry Epstein, Capital District Psychiatric Center

"During our association with the peer bridgers from this (Ulster) program, we have found them to be helpful in reaching out to patients who might be afraid of leaving the hospital because of long lengths of stay in inpatient settings or because of negative experiences in the community. The peer bridgers are able to use their training and their own personal experiences to help reach and engage many of our patients. At this time we..face an enormous challenge–to significantly reduce our inpatient population..Additional peer bridgers would facilitate this process both in our own catchment area and in the NYC and Westchester County areas. We..are hopeful that OMH will be able to support the requests being made by NYAPRS...for funding to expand the peer bridger program in New York State."
Claire Newquist, Director of Program Operations, Hudson River Psychiatric Center

HOW DO BRIDGER STAFF VIEW THE PEER BRIDGER PROGRAM?

"An Evaluation of the Peer Bridger Initiative" Cheryl MacNeil, Principal Investigator, August 1996

88% of those bridgers interviewed agreed that their involvement with the Peer Bridger project has helped them in their recovery. Responses not only reflected that the project contributed toward recovery, but many statements made by bridgers dispel an initial concern expressed by some that the project could be too stressful for bridgers. Comments reflecting the impact of the project on the personal recovery of bridgers included such statements as:

"My self-esteem is very low and for me to have a job right now is very important to my mental health. It helps to have the support system of other bridgers."

"It has given me a lot of nightmares about being in the hospital and the powerlessness and the frustration of the way people get looked at. It's helped me to see that recovery has very little to do with the hospital and what works is self-help and peer counseling".

"At times its stressful but it has brought me back to a lot of issues. My problems are similar to (those of the person I am matched with) and it makes me sad, but it enables me to work on it and be stronger for her. It gives me support."

"It has made me more sympathetic to others. I've become more outgoing and I've learned to have to keep things confidential."

Peer-Bridger Project Program Evaluation Research

Prepared by National Health Data Systems December 1998

Findings for the BRIDGERS Group

Rehospitalization Rates

It appears that the program not only works for Matches, but for Bridgers as well. Although not reaching statistical significance, the average follow-up rehospitalization rate for Bridgers was zero (0%), down from the baseline hospitalization rate of 4%. It is clear, therefore, that Bridgers suffered no difficulty as a result of playing that role, but it may have even strengthened them. This is not surprising, as similar "companioning" has been shown to sustain recovery in other such programs (e.g., AA).

WHO DOES THE PROJECT SERVE..AND WITH WHAT RESULTS?

Peer-Bridger Project Program Evaluation Research

Prepared by National Health Data Systems December 1998

Results from the 1996 Initial Report

Since enrolling in the program:

- The program members' ability to cope with stressful situations showed *substantial improvement.*
- The members' self-confidence *improved modestly.*
- Many members continue to experience symptoms regularly, but manage/cope with them better than before the program.
- Many members have become active as advocates for a variety of reasons.

Moreover, the members gave the program high marks:

- They rated Peer-Bridger Project *highly positive.*
- They said the chief benefits from self-help groups are helping others and providing insight into coping.

Results of 1998 Study

Demographics of the Match Group

Diagnosis

33% Personality Disorder (Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, etc.
33% Schizophrenia
11% Bipolar Disorder
11% Schizoaffective Disorder
6% Depressive Disorder (Major Depressive Disorder, Dysthymic Disorder)
6% Dissociative Disorder

Ethnic Background

50% White (Non-Hispanic) 6% Asian/Asian-American
17% Black (Non-Hispanic) 28% Other

Age

33% 20-29 Years 22% 30-39 Years 7% 40-49 Years 17% 50-59 Years 11% 60-69 Years

Gender

50% Males 50% Females

Substance Abuse and Physical Handicaps

39% reported having a Substance Abuse problem
28% reported having a Serious Physical Handicap

Rehospitalization Rates

"The most substantial finding is that **the follow-up rehospitalization rate of Matches while enrolled in the Peer-Bridger Project was significantly less than the baseline hospitalization rate (i.e., the 2-year period prior to enrollment).** That is, during the 2-year baseline period, the Matches were hospitalized an average of **60%** of the time; while enrolled in the program, however, they were rehospitalized only **19%** of the time. That's an **improvement of 41%**!"

CONCLUSION

The collaboration between the NYS Office of Mental Health, its state facilities, local county mental departments and the New York Association of Psychiatric Rehabilitation Services has resulted in a nationally recognized innovative initiative that, in introducing the power of peer-supported recovery to state hospitals and surrounding localities, has successfully:

- helped hundreds of individuals with "high service needs" who have typically required long or repeated stays in state hospitals to successfully transition back to local communities
- provided another thousand individuals with access to a vital network of weekly peer support groups
- trained over a thousand state and community mental health staff to better appreciate and support a newly developing environment that supports the recovery, rehabilitation and rights of New Yorkers with psychiatric disabilities while
- providing important new entry-level employment opportunities in human services for over a hundred individuals

Over the past 5 years, NYAPRS has continued to refine this pioneering demonstration project with universally acclaimed results: ***PEER BRIDGING WORKS!***

For more details, contact NYAPRS Executive Director Harvey Rosenthal at 518-436-0008, or nyaprs@aol.com.

Appendix B

Certified Peer Specialist Job Description

Georgia Certified Peer Specialist
Job Description, Responsibilities, Standards and Qualifications

Under immediate to general supervision, the Certified Peer Specialist (CPS) provides peer support services; serves as a consumer advocate; provides consumer information and peer support for consumers in emergency, outpatient or inpatient settings. The CPS performs a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. The CPS will role model competency in recovery and ongoing coping skills.

1. Using the 10-step goal setting process the CPS will:
   a. Assist consumers in articulating personal goals for recovery.
   b. Assist consumer in determining the objectives the consumer needs to take in order to reach his or her recovery goals.

2. The CPS will document the following on the Individual Service Plan (ISP) by:
   a. Assisting consumers in determining "Problems."
   b. Assisting consumers in identifying recovery goals.
   c. Assisting consumers in setting objectives.
   d. Determining interventions based on consumers recovery/life goals.
   e. Observing progress consumers make toward meeting objectives.
   f. Understanding and utilizing specific interventions necessary to assist consumers in meeting their recovery goals.

3. Utilizing the CPS' specific training the CPS will:
   a. Lead as well as teach consumers how to facilitate Recovery Dialogues by utilizing the Focus Conversation and Workshop methods.
   b. Assist consumers in setting up and sustaining self-help (mutual support) groups.
   c. Assist consumers in creating a Wellness Recovery Action Plan (WRAP).
   d. Utilize and teach problem solving techniques with individuals and groups.
   e. Teach consumers how to identify and combat negative self-talk.
   f. Teach consumers how to identify and overcome fears.
   g. Support the vocational choices consumers make and assist them in overcoming job-related anxiety.
   h. Assist consumers in building social skills in the community that will enhance job acquisition and tenure.
   i. Assist non-consumer staff in identifying program environments that are conducive to recovery; lend their unique insight into mental illness and what makes recovery possible.

j. Attend treatment team meetings to promote consumer use of self-directed recovery tools.

4. Utilizing their unique recovery experience the CPSs will:
   a. Teach and role model the value of every individual's recovery experience.
   b. Assist the consumer in obtaining decent and affordable housing of his or her choice in the most integrated, independent, and least intrusive or restrictive environment.
   c. Model effective coping techniques and self-help strategies.

5. Maintain a working knowledge of current trends and developments in the mental health field by reading books, journals and other relavent material.
   a. Continue to develop and share recovery-oriented material with other CPSs at the continuing education assemblies and on the CPS electronic bulletin board.
   b. Attend continuing education assemblies when offered by the CPS Project.
   c. Attend relevant seminars, meetings, and in-service trainings whenever offered.

6. Serve as a recovery agent by:
   a. Providing and advocating for effective recovery based services.
   b. Assist consumers in obtaining services that suit that individual's recovery needs.
   c. Inform consumers about community and natural supports and how to utilize these in the recovery process.
   d. Assist consumers in developing empowerment skill through self-advocacy and stigm-busting.