Nebraska Peer Support Focus Group/Survey Report

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

Survey Results

Demographic Information

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

Table 1: Number of Survey Participants by Respondent Type

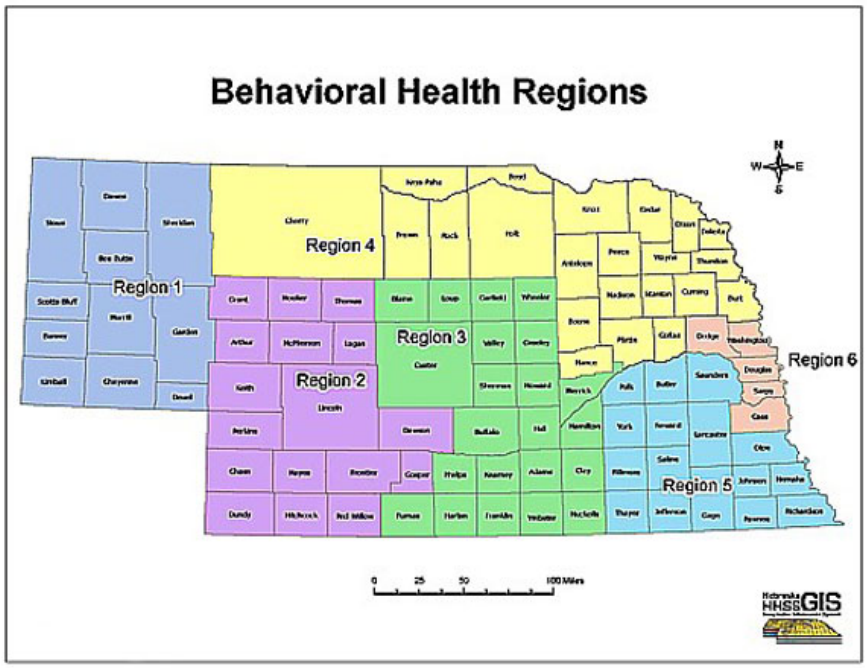
	Adult Consumer	Family Consumer	Adult Peer Specialist	Family Peer Specialist
Overall number of valid surveys	70	34	16	26

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

Table 2: Demographic Characteristics by Survey Respondents by Respondent Group

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

The Behavioral Health Regions are shown in Figure 1:



Trauma

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

^Item 18 was not part of the original scale

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

Consumer Satisfaction

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

1= Strongly disagree
2= Disagree
3= Neither agree nor disagree
4= Agree
5= Strongly agree

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

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

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

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

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

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

Peer Support Services

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

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

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

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

	Adult Peer Specialist	Family Peer Specialist
What proportion of your work time do you currently spend providing peer support services?		
0-25%	14.3% (2)	8.3% (2)
26-50%	35.7% (5)	12.5% (3)
51-75%	7.1% (1)	25.0% (6)
76-99%	28.6% (4)	37.5% (9)
100%	14.3% (2)	16.7% (4)
What proportion of your time is spent working with individuals with mental health and/or substance abuse issues?		
Mostly mental health	40.0% (6)	36.4% (8)
Mostly substance abuse	0% (0)	0% (0)
Mostly co-occurring mental health and substance abuse	26.7% (4)	40.9% (9)
Equally divided among mental health, substance abuse and co-occurring disorders	33.3% (5)	22.7% (5)
What is the average hourly rate you are paid for peer support services?		
$0	15.4% (2)	0% (0)
$1-$10/hour	7.7% (1)	29.2% (7)
$11-$20/hour	69.2% (9)	62.5% (15)
$21-$30/hour	7.7% (1)	8.3% (2)
Over $30/hour	0% (0)	0% (0)
How many years have you provided peer support services?		
0-5 years	66.7% (10)	66.7% (16)
5-10 years	26.7% (4)	20.8% (5)
10-15 years	0% (0)	8.3% (2)
Over 15 years	6.7% (1)	4.2% (1)
What is your job title?		
Peer Support and Wellness Specialist	26.7% (4)	0% (0)
Peer Specialist (asked only of Adult Specialists)	6.7% (1)	
Navigator (asked only of Adult Specialists)	0% (0)	
Recovery Specialist (asked only of Adult Specialists)	6.7% (1)	
Advocate (asked only of Adult Specialists)	0% (0)	
Family Peer Support Specialist (asked only of Family Specialists)		4.2% (1)
Family Navigator (asked only of Family Specialists)		8.3% (2)
Family Partner (asked only of Family Specialists)		0% (0)
Family Advocate (asked only of Family Specialists)		54.2% (13)
Other (please specify) *Adult Peer Specialists* • Certified Peer Support and Wellness Specialist for Employment • Consumer Specialist • Consumer Specialist Peer Recovery Facilitation • Peer Companion [2 responses] • Peer Employment Specialist	60.0% (9)	33.3% (8)

	Adult Peer Specialist	Family Peer Specialist
• Peer Support Specialist • [2 did not specify] *Family Peer Specialists* • administration • Executive Director [2 responses] • Family Advocate and Office Manager • Family advocate, program manager • Family Navigator and Family Advocate • Review Specialist • Services Coordinator; Family Support Worker		
Do you supervise other peer support specialists?		
Yes	26.7% (4)	41.7% (10)
No	73.3% (11)	58.3% (14)
How would you characterize the agency you work for?		
Community Mental Health Agency	6.7% (1)	4.2% (1)
Hospital	0% (0)	0% (0)
Consumer Organization	26.7% (4)	4.2% (1)
Family Organization	0% (0)	87.5% (21)
Behavioral Health Region	20.0% (3)	0% (0)
Independent (provide services on your own)	6.7% (1)	0% (0)
Other (please specify) *Adult Peer Specialists* • Adult Day Program • Community Mental Health Agency and Omaha Police • Hospital, non-profit • Mental Health & Substance Abuse • Non-profit organization [2 responses] *Family Peer Specialists* • Oversight Agency	40.0% (6)	4.2% (1)

Training

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Focus Group Results

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

Peer Support Services in General

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

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

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

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

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

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

Peer Support Resources/Expansion

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

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

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

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

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

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

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

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

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

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

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

Coordination of Peer Support

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

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

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

Relations with Other Providers/Marketing

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

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

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

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

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

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

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

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

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

Skill Development

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Trauma Informed Care.

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

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

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

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

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

Summary and Conclusions

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

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

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

Key findings from the focus groups include the following:

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