



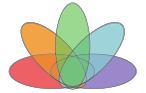
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Recovery Support  
Services Program  
2017 - 2018

**Program Evaluation  
and Playbook**

July 2018

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The **Recovery Support Services Program** was developed by the Colorado Mental Wellness Network with assistance from its partners at the Denver Public Library, Denver Human Services - Office of Behavioral Health Strategies, and the University of Colorado - Behavioral Health & Wellness Program.

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# Executive Summary

With help from its partners, the Colorado Mental Wellness Network (CMWN) led a collaborative effort to improve recovery support systems and processes in Denver – the **Recovery Support Services Program**. In 2017 and 2018, the Program expanded the network of Peer Support Specialists employed at the Denver Public Library (DPL) by launching the “It Takes a Library” pilot program, trained additional providers across a spectrum of organizations and agencies in the use of Wellness Recovery Action Plans (WRAP®), increased awareness of service offerings, decreased stigma around recovery, and implemented an evaluation framework to encourage replication of this model across the state.

Evaluation of this innovative program indicates that, with the supervision of experienced social workers and the support of an established peer-run organization within the community, Peer Support Specialists installed in public libraries are an effective model for improving recovery support systems in urban settings such as Denver. Moreover, the Program made significant progress introducing Denver providers working across a broad range of social service and health care agencies to a recovery-oriented perspective and peer-led services, including WRAP®.

The program evaluation described throughout this document reflects the realistic expectation that a ‘culture of data’ must be incrementally established in any non-academic setting. However, multiple lines of evidence clearly suggest that the Program was well-received by key stakeholders. Several avenues for replicating or expanding the project (in terms of the size of its service population and/or the number or diversity of site locations) remain available for CMWN, DPL, Denver Human Services, and/or other interested parties to consider.

## About this Document

This program evaluation and playbook provides information and practical guidance for social service professionals and leaders in the field who are considering implementing a recovery support program for priority populations within their communities or organizations. Material included within this publication is designed for use by senior leadership, state and local funders, program managers, clinicians, social service professionals, community health workers, and Peer Support Specialists.

Information in this document is based on a program evaluation conducted by the Behavioral Health and Wellness Program, along with the collective experiences of those who spearheaded, developed, and implemented the Recovery Support Services Program.

This playbook is designed to facilitate similar program implementation within other non-traditional settings by guiding readers through the activities implemented and offering pragmatic recommendations.

Additionally, this document provides an assessment of the replicability of the model, the impact on individuals and the community, the ability of the program to achieve its goals and objectives, and the program’s sustainability. Throughout, we share stories of project successes, challenges, and lessons learned.

## Acronyms

**BHWP** – Behavioral Health & Wellness Program

**CMWN** – Colorado Mental Wellness Network

**DHS** – Denver Human Services

**DPL** – Denver Public Library

**IC&RC** – International Credentialing & Reciprocity Consortium

**iNAPS** – International Association of Peer Supporters

**OBH** – Office of Behavioral Health

**PHASE** – Probation and Parole Accountability Stabilization Enhancement Program

**PSS** – Peer Support Specialist

**SAMHSA** – Substance Abuse and Mental Health Services Administration

**WRAP**<sup>®</sup> – Wellness Recovery Action Plan



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# Introduction

## Background

Over the past decade, the concept of recovery has gained increased traction within the healthcare industry, social service organizations, and the justice system. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), recovery is defined as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” As organizations evolve their focus to include recovery and resiliency, there is a corresponding shift toward the engagement of individuals as informed and decisive directors in their lives. This self-management approach has been successfully implemented in the treatment of a variety of chronic physical health conditions, behavioral health conditions, and co-occurring medical conditions among individuals with behavioral conditions, as well as with specific populations including justice-involved individuals and the military.

This shift in attention towards recovery and self-management highlights the important role that individuals play in their own recovery as well as in the recovery journeys of their peers. Peer Support Specialists (PSSs) are people who are trained to use their personal recovery experiences to help guide, inspire, advocate for, and empower others who are not as far along in their own recovery. While many organizations may recognize the value and importance of incorporating peer support personnel into their teams, strategies to create effective and sustainable programs are less well known.

## Priority Populations

Individuals with overlapping vulnerabilities and risk factors have complex needs, which are often undermanaged and which are not adequately treated within fragmented systems of care. The Recovery Support Services Program (“the Program”) seeks to increase access to care and recovery support services for these individuals. The priority population comprises those individuals living at the intersection of homelessness or socio-economic disadvantage, criminal justice involvement, mental

health conditions, and/or substance use conditions. These risk factors render individuals highly vulnerable to a variety of life challenges and are associated with high degrees of service utilization.

Between 2016 and 2017, the rate of individuals experiencing homelessness nationally increased – for the first time in seven years – by just under 1% (Henry et al., 2017). By comparison, the rate of individuals experiencing homelessness in Colorado increased by approximately 6% from 2015 to 2017 (Henry et al., 2016; 2017). As of January 2017, there were an estimated 10,940 Coloradans experiencing homelessness: 7,571 individuals (763 of which were unaccompanied youth) and 3,369 people in families. A significant portion of these individuals were located in the Denver Metro region, with the most recent point-in-time analysis finding that over 5,000 individuals are experiencing homelessness in Denver alone (Metro Denver Homeless Initiative, 2018). Each year in Colorado, about 260,000 individuals need treatment for severe mental illness (Brown, 2014), yet many are unaware of available services or how to access them. Within Denver, individuals who are experiencing homelessness self-report mental illness at rates of 34%; estimates are likely even higher when diagnosed by psychiatric professionals (“For Colorado Homeless,” 2016). Moreover, homelessness and behavioral health conditions are associated with additional demographic factors known to predict poor health and chronic disease, particularly poverty and criminal justice involvement.

Individuals from priority populations experience multiple barriers to accessing care. Low socioeconomic status, mental health conditions or substance use conditions, and criminal justice involvement are all demographic characteristics that can trigger stigma, implicit (unconscious) bias, and explicit (conscious) bias from members of the community and service providers. As a result, persons within disenfranchised groups are often distrustful of healthcare and other service providers, which in turn decrease their access to services and increases disparities in health outcomes.

## Target Settings for Service Connections

Vulnerable populations often have complex needs requiring coordinated continuity-of-care services bridging a broad range of service providers, yet they are among those least likely to receive any recovery support services through traditional avenues. If services are positioned where at-risk populations are more able to access them, any point of intervention or service can become a hub of care and resources. This perspective is well aligned with the patient-centered medical neighborhood model, wherein a broad range of providers, patient navigators, and community service providers are instrumental in helping establish and ensure continued care coordination for priority populations. The Program targeted the Denver Public Library and Denver Human Services (and its associated organizations and agencies) as the primary hubs of service provision for the target population.

## Recovery Support Services Program

### Program Goals

The central tenet guiding this initiative is that two of the social service sector's primary challenges are: 1) to reduce the stigma surrounding treatment and recovery and 2) to find ways for fragmented systems of care to better coordinate services for individuals with complex, overlapping needs.

In February of 2017, the Recovery Support Services Program was launched, with the purpose of equipping service providers and Peer Support Specialists in Denver with the training and tools required to help this particular priority population decrease service need and utilization, improve mental health symptoms and recovery outcomes, and increase access to necessary and appropriate recovery services.

Specifically, the Program had four goals:

1. Increase the ability of individuals to access services by expediting and improving transitions between agencies and increasing awareness of recovery support services;
2. Reduce the target population's law violations and potential for becoming a crime victim;
3. Use an evidence-based approach to enhance the effectiveness of Denver's system of care to decrease criminal justice involvement among individuals with high behavioral health needs;
4. Enhance existing recovery support services in the City and County of Denver with additional opportunities for peer training and unrestricted access to peer support providers.

### Program Partners

#### *Colorado Mental Wellness Network (CMWN)*

Founded in 2002, CMWN is the only statewide, peer-run organization in Colorado focused on recovery. Through education and advocacy, CMWN's mission is to provide opportunities for individuals in recovery to improve the quality of their lives, give back to the community through meaningful roles, and to change the perceptions of mental health.

#### *Denver Public Library (DPL)*

DPL is increasingly filling a service gap by helping to provide the priority population with access to human services including benefits, substance use counseling, and crisis and mental health services. To meet this community need, DPL has operated a social work department since 2014. In 2015, DPL received funding to initiate a PSS program and provide clinical supervision through on-site social work department staff.

#### *Denver Human Services (DHS)*

As the primary coordinator and deliverer of public health and human services in Denver, DHS provides case management and client service coordination. DHS's Office of Behavioral Health Strategies

advertises, coordinates, and conducts internal and external Wellness Recovery Action Plan (WRAP®) informational sessions and workshops for both DHS staff and priority populations.

### *Behavioral Health and Wellness Program (BHWP)*

BHWP is an academic program housed within the Department of Psychiatry at the University of Colorado Anschutz Medical Campus. BHWP provides health and wellness advocacy, training, consultation, and evaluation services to providers, organizations, public health departments, and criminal justice programs across more than 30 states.

### Activity Overview

The Program is currently comprised of two key components:

1. Creation and expansion of peer support services at DPL with the pilot program, “It Takes a Library”;
2. Promotion and expansion of the use of the evidence-based WRAP® curriculum across service providers in Denver and individuals in recovery.

These two primary activities, although complementary, need not be implemented concurrently. Rather, each serves as stand-alone solutions to the challenge of expanding access to recovery services for this target population.

Accordingly, this document is organized into two main sections, each of which corresponds to one of the primary activities.

## Evaluation Overview and Data Sources

With the assistance of the project partners, BHWP developed and coordinated qualitative and quantitative data collection processes with the goal of evaluating the Program’s efficacy, scalability, and sustainability.

## Peer Support Services at DPL

Activities conducted at DPL were evaluated using:

1. Semi-structured key informant interviews of DPL staff members and key personnel at public libraries with similar PSS programs located in the San Francisco and Chicago metro areas (See *Appendix A* for the interview script)
2. Semi-structured key informant interviews of Peer Support Specialists at DPL (See *Appendix K* for the interview protocol, script, and summary report)
3. Quantitative [survey](#) of DPL Peer Support Specialists (See *Appendix B* for survey and responses)
4. Quantitative surveys of library staff at DPL (See *Appendix C* for survey and *Appendix D* for survey responses)
5. Tracking forms for all customer contacts with the target population at DPL over the course project (See *Appendix E*)

Findings from all interviews and surveys were analyzed and summarized by the evaluation team. Qualitative data from key informant and PSS interviews informed much of the general information provided in the text, and specific statements can be found in the quote boxes throughout document. Quantitative data from surveys administered to PSSs and DPL staff are presented in the “Program Evaluation” section, and are summarized in figures and tables.

### WRAP® Expansion

To evaluate progress made in expanding the use of WRAP® across service providers in Denver and individuals in recovery, project partners collected data on workshop attendance, participant demographics, and participant satisfaction. Additionally, baseline (*Appendix I*) and [follow-up](#) surveys have been developed to evaluate the utility and efficacy of WRAP®. Initial baseline data related to resiliency and coping self-efficacy are presented.

# Part I — Peer Support Services at DPL: “It Takes a Library”

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*I got to be the person I needed years ago.*

- Peer Support Specialist at DPL

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## The Power of Peers

Peer Support Specialists are individuals with lived experience of chronic physical or mental health conditions, substance use conditions, homelessness, and/or involvement in the criminal justice system. Due to these lived experiences, PSSs possess unique skills that can be leveraged to connect marginalized populations with social services, resources, and healthcare. Peer support programs are effective. A literature review found that PSSs are qualified to enhance several aspects of recovery including hope, empowerment, self-esteem, self-efficacy, social inclusion, and engagement (Repper & Carter, 2011).

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*Peers...can work with people on a different level...they bring a different energy to the work.*

- Peer Support Specialist at DPL

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## Program Background

In 2015, DPL hired its first social worker to address the increasing role played by library staff members in addressing customers’ needs for immediate access to resources, social services, and healthcare. Rising rates of individuals experiencing homelessness in Denver, in conjunction with a sharp increase in EMS calls and opioid overdose fatalities (particularly in the area surrounding DPL), has resulted in the need for several new hires at DPL over the past two years, including additional security personnel and a second social worker.

The Recovery Support Services Program at DPL stemmed from successful efforts by the library’s social work department to obtain grant funding from Telligon and Metro Denver Homeless Initiative in partnership with CMWN and DHS. The first grant was awarded in 2016, providing funds for three Peer Support Specialists who began their work at DPL in early 2017. This funding was soon supplemented by the addition of a second grant from the Colorado Department of Human Services, Office of Behavioral Health (OBH) in January 2017. This funding enabled partners to launch the current pilot program, “It Takes a Library”, which allowed for a fourth PSS and a more concerted effort to expand recovery services across Denver, as well as to develop a more rigorous evaluation framework.

In 2018, the City and Country of Denver recognized the value of peer support and the success of this program. Social workers at DPL developed a presentation (*Appendix F*) for the Mayor’s Chief of Staff and Budget Office which led to a successful bid to create city-funded positions for six Peer Support Specialists at DPL at 30 hours per week, starting in July of 2018.

## Program Design

The central component of the pilot program is the team of PSSs who initiate and receive direct contact from the priority population. (Note: the term “Peer Navigator” is used at DPL to describe PSSs, however for clarity, the term “Peer Support Specialist” is used throughout this document). The PSSs’ report to licensed, clinical social workers at DPL. PSSs are provided extensive training by CMWN before beginning their service responsibilities. After beginning their positions, they are supported by clinical supervision, ongoing training opportunities, and supportive management structures.

Today, the “It Takes a Library” pilot program can be viewed as having three tiers:

1. Lead Social Worker and CMWN
2. Social Workers
3. Peer Support Specialists

This tiered system allows for a distribution of effort and task specialization.

PSSs handle the majority of direct work with the priority population, including being present for drop-in hours, conducting outreach, referring customers to community resources, providing emotional support, developing relationships with regular customers, and providing bus passes and other basic supplies.

Because PSSs provide these services, social workers maintain greater availability to handle crisis situations, organize and conduct staff trainings, and provide supervision to PSSs.

### Three Tiers of the “It Takes a Library” Program



Figure 1: Program 3-Tier System

Additionally, the tiered system has allowed more time for the library’s social work department to engage in programmatic efforts, including co-chairing collective impact opioid work with the City and County of Denver, representing DPL within the social services sector, sharing information with city planning groups and other organizations, working with the security manager to sustain programs, and developing collaborations with other partners (e.g. laundry services, family services, etc.).

## PSS Hiring, Core Competencies, and Professional Development

Prior to their placement at DPL, PSSs attended an [80-hour training program for Peer Support Specialists](#) developed and provided by CMWN. The training was first created in 2012 with the support of the International Association of Peer Supporters ([iNAPS](#)) and has been updated each year to include current information and practices. This training meets and exceeds the competency standards as established by the Colorado Behavioral Healthcare Council and the International Credentialing and Reciprocity Consortium ([IC&RC](#)). It also meets the new national standards for Peer Support Workers that have been published by SAMHSA. Any program developing peer training should aim to meet those standards as well.

During the CMWN training, students hone their skills through role plays, group projects, and practice elements. Students learn to build on their lived experience in order to assist others. Training topics include: supporting wellness and recovery, advocacy, ethics, communication skills, self-care, boundaries, resilience, and trauma informed support.

Another key component of the training is a firm understanding of the distinct role of peers and the ethical principles of peer work. The iNAPS’ document, National Practice Guidelines for Peer Supporters (available at the [iNAPS website](#)) provides guidance on these topics and is used throughout the training.

Upon course completion, graduates are qualified to sit for the IC&RC Certification Exam through the Colorado Providers Association.

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*This was deeply thoughtful, immensely challenging, and I learned an amazing amount of information to benefit myself and others.*

- Graduate of CMWN PSS Training

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The CMWN Peer Support Specialist training program provided a pool of highly qualified candidates from which potential applicants for employment with the “It Takes a Library” pilot program were identified, interviewed by the lead DPL social worker and Security Manager, and subsequently hired.

The PSSs are compensated the industry standard wage, and raises were given after PSSs had been in their roles for one year. CMWN also reimbursed parking and paid for bus passes to commute to and from work.

In addition to the initial training provided by CMWN, ongoing training for PSSs at DPL is prioritized. Soon after they were hired, PSSs participated in multiple trainings with topics such as “trauma informed systems of care”, “resilience training”, and “homelessness 101”. More recently, PSSs received training on Motivational Interviewing. One PSS commented, “I cannot say enough how [the social work supervisor] is great about training.”

These training opportunities are extended to other library staff as well. In 2017 the social work department, based in part on a request from the PSSs, spearheaded an effort to make Narcan, a medication for opioid overdoses, available at the library. The entire library security department, social workers, and PSSs were provided the opportunity to receive training on administering Narcan. So far, the team has reversed 14 opioid overdoses at DPL.

## Customer Connections

At a practical level, PSSs assist individuals with finding resources such as temporary housing, food, and transportation; obtaining important documents (e.g. IDs, Social Security Cards); acquiring referrals to social services such as mental health or substance use treatment; and with tasks requiring computer or health literacy (e.g. securing insurance, filing for unemployment, signing up for benefits).

There are three modes by which the priority population is reached and provided the resources they need:

1. Drop-in hours
2. Outreach
3. Per-incident staff assistance

The library hosts “drop-in hours” every Monday-Friday, either from 10am-1pm or from 2-5pm. Anyone may visit the PSSs for assistance during drop-in hours. Grant funds were used to provide free city bus passes for customers seeking services during drop-in hours. Additionally, PSSs participate in “outreach,” during which they visit every floor of the library along with the area immediately outside the building, offering assistance. PSSs approach DPL customers who they perceive may be struggling in some way (e.g., crying, engaging in an altercation with another patron, not adequately dressed for inclement weather) and offer help directly. Emergency supplies including water, snacks, socks, toothbrushes, and other hygiene necessities are provided both at drop-in hours as well as during outreach as an effort to build trust among members of the target population and engage them in the possibility of seeking additional support services.

Library staff also request PSS support with customers. Several staff members and PSSs highlighted the importance of PSSs being “visible” on the floors of DPL. In addition to building trust among potential customers, maintaining a consistent presence around the library served to increase library staff’s understanding of the role played by PSSs. For example, some situations are best handled by the peers, other incidents may be elevated either to the social workers or to security, and still others do not warrant additional attention at all. The visibility of PSSs also increased the likelihood that staff would request assistance from them and refer customers to them in appropriate situations.

Importantly, PSSs offer customers far more than practical assistance. They offer people a human connection, emotional support, empathy, courtesy, and respect.

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*People just need to be listened to. The people we see are not treated well, so no one listens to them with respect and with mindfulness and attentiveness.*

- Peer Support Specialist at DPL

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## PSS Professional Support

A disproportionate number of individuals experiencing homelessness first experienced trauma, and this is true both for people *seeking* and *providing* peer support services. The experience of becoming or being homeless is traumatic in and of itself. And of course, life on the streets or in shelters provide opportunities for further victimization. This is often aggravated by both governments and citizens who compound the trauma further through unsympathetic public policy.

CMWN and DPL designed the pilot program to be sensitive to the significant demands placed on PSSs due to the needs of the priority population as well as the peers' own experiences. The PSS positions at DPL are designed to be part-time (i.e. 20-30 hours per week maximum) both to prevent burnout and to allow extra time for self-care. At DPL, two experienced social workers with clinical training supervise the PSSs. The entire team meets together weekly, and the social workers meet individually with PSSs for an additional 30 minutes per week. PSSs also meet as a group with an experienced staff member at CMWN for one hour of weekly supervision, described by one PSS as "like a support group."

Opportunities for personal and professional support for PSSs happen daily, as they typically meet with social workers for brief check-ins at the beginning and end of each day. PSSs are always encouraged to seek support from social workers and each other when faced with difficult situations.

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*When I see in someone's eyes after we have talked, I can see gratitude in their eyes and I see appreciation in their eyes. I see connection and caring that they are happy that they got to interact with me and they are grateful. That is what makes my day.*

- Peer Support Specialist at DPL

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## Program Evaluation

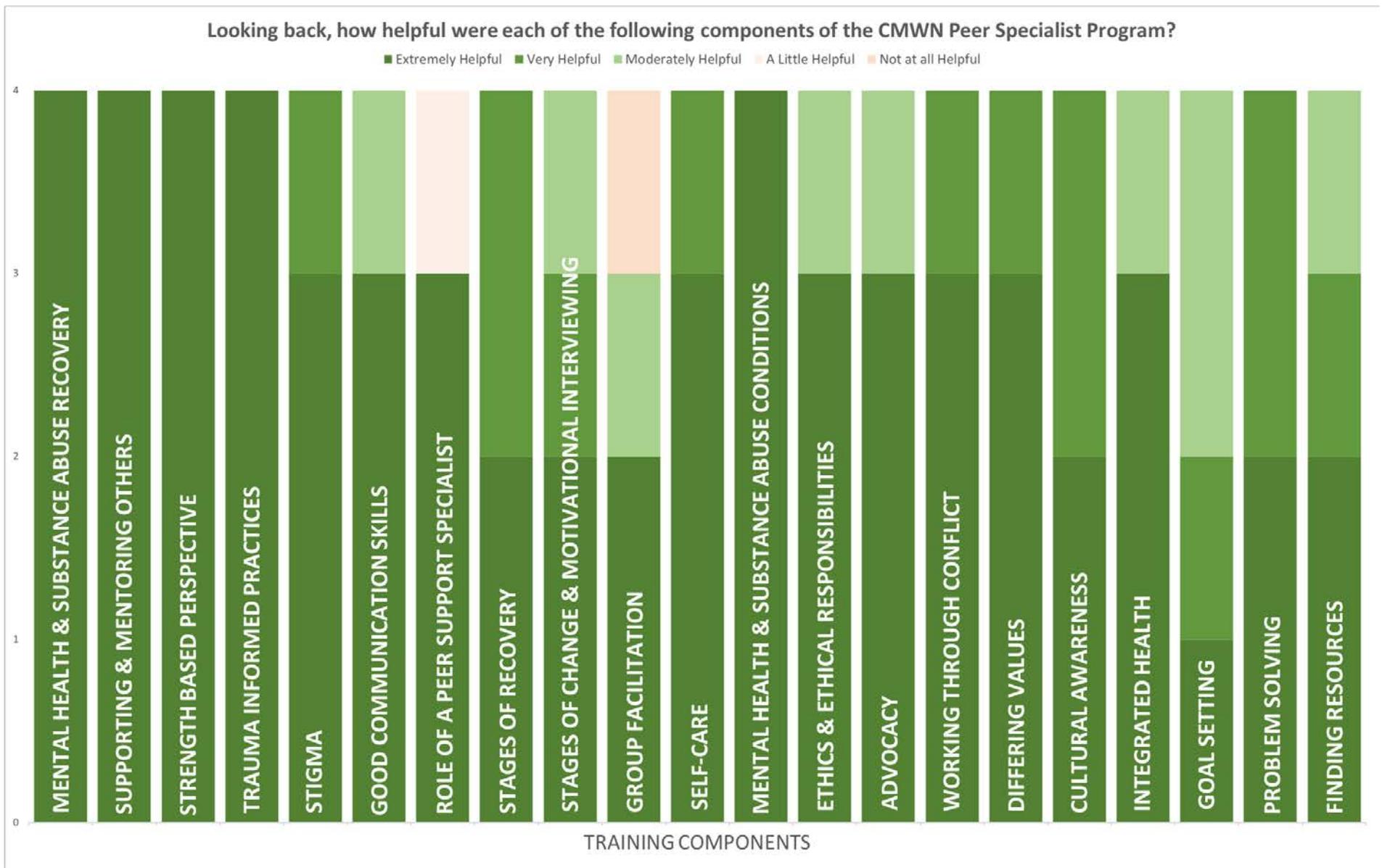
In order to evaluate various components of the "It Takes a Library" pilot program, both quantitative and qualitative data were collected to: 1) assess Peer Support Specialist experiences, 2) characterize the nature of the connections formed with and services provided to customers by PSSs and social workers, and 3) evaluate the impact of the pilot program at DPL. Due to unique characteristics of the priority population (e.g., distrust of authorities, criminal justice system involvement, behavioral health conditions) and concerns over confidentiality, this evaluation did not include patron-level outcomes.

### Experiences of Peer Support Specialists

To evaluate the experiences of Peer Support Specialists at DPL, an online survey was administered using the Qualtrics survey platform about one year after the launch of "It Takes a Library". All four PSSs completed the approximately 15-minute survey, and responses were received directly by the independent evaluator, BHWP. Individual responses were never shared with the PSS employer, CMWN, nor with the PSS supervisors at DPL. (A link to preview the survey in its entirety and a summary of survey responses can be found in *Appendix B*.)

### Training and Professional Competency

PSSs were surveyed about their perceptions of the training they received prior to working at the library. Specifically, they were asked "Looking back, how helpful were each of the following components of the CMWN Peer Specialist Support Training to the work you are currently doing as a PSS?" (*Appendix B, Table 1*); participants were presented with 21 training components to consider. Overwhelmingly, participants found most training components to be "extremely" or "very" helpful (*Figure 2*).



**Figure 2: PSS-reported helpfulness of the CMWN PSS Training components.** Bars are divided into four sections, one section per respondent (N = 4). The colors of the sections indicate the response option for each individual PSS.

PSSs were also asked whether they would like to receive additional training on any of the core competencies. All four PSSs reported they would like to receive more training on “stages of change and motivational interviewing.” When asked which topics they would *most* like to receive additional training on, two PSSs selected “group facilitation” and two selected “stages of change and motivational interviewing.” PSSs also endorsed each of the following as topics they would like more training on. The number in parentheses represents the number of PSSs (out of 4) endorsing each topic:

- Ethics and ethical responsibilities (2)
- Goal setting (1)
- Group facilitation (2)
- Integrated health (1)
- Mental health & substance use conditions (1)
- Stages of change & motivational interviewing (4)
- Stages of recovery (1)
- Stigma (1)
- Supporting & mentoring others (1)
- Trauma informed practices (1)
- Working through conflict (1)

Two survey questions provided information on PSSs’ overall opinions regarding training and supervision. These asked respondents to agree or disagree with the following two statements: “Overall, the CMWN PSS Training prepared me well for my role as a PSS.” and “Supervision I receive is valuable.”

All four PSSs either “strongly agreed” or “somewhat agreed” with the first statement. Interestingly, whereas two PSSs “strongly agreed” that supervision was valuable, two others were ambivalent about the value of supervision (“neither agree nor disagree”).

Ten survey questions assessed PSSs’ knowledge of, and comfort with, various aspects of their role as a PSS, that is, specifically as providers or resources and referrals. They were instructed, “Please indicate the extent to which you agree or disagree with the following statements” (*Appendix B, Table 2*). All PSSs “agreed” or “strongly agreed” with the statement, with half of the items receiving unanimous “strong” agreement (Figure 3).

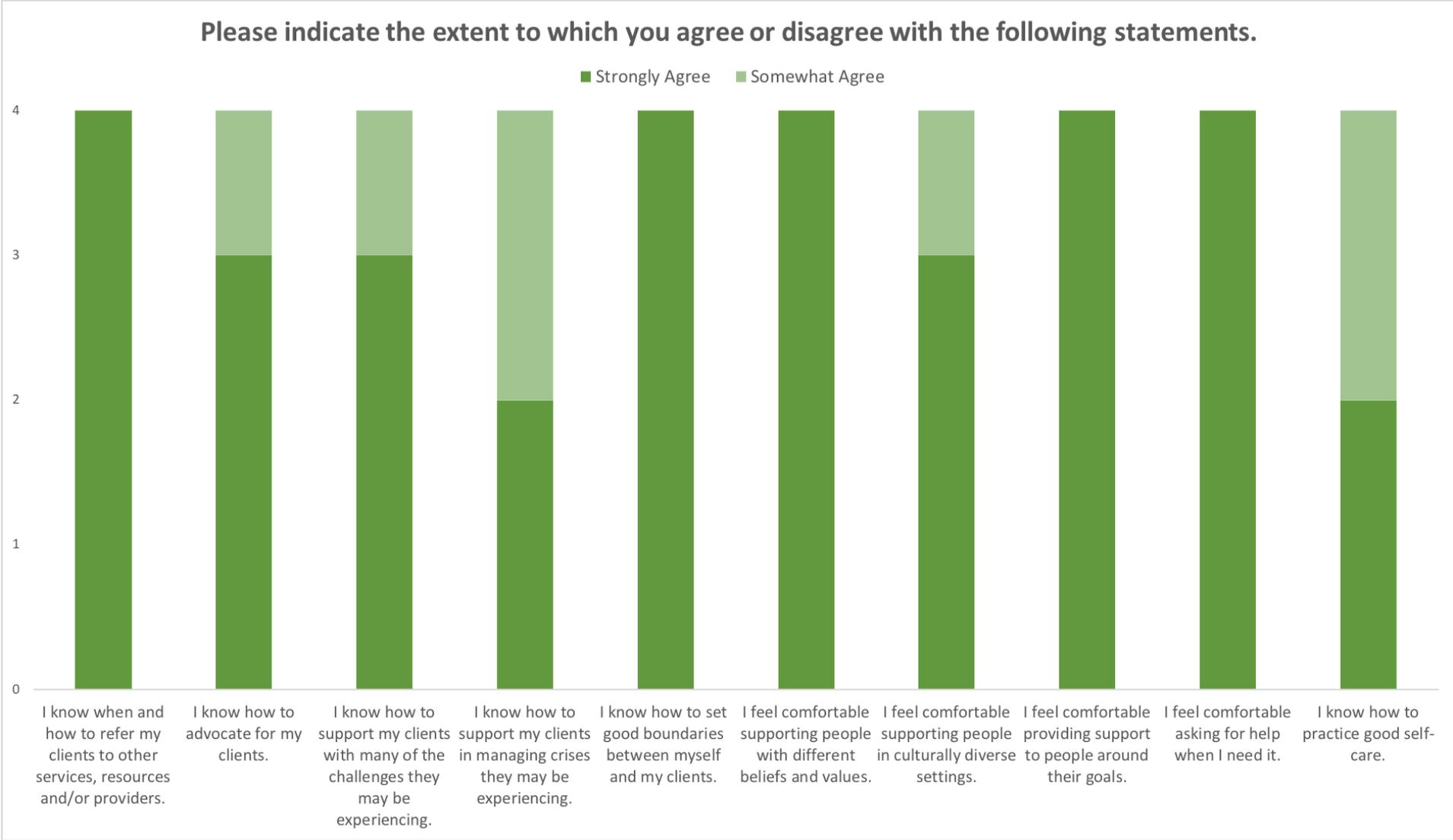
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*The training I received was game changing.*

- Peer Support Specialist at DPL

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**Figure 3: PSS-reported knowledge and competencies.** Bars are divided into four sections, one section per respondent (N = 4). The colors of the sections indicate the response option for each individual PSS.

## Daily Activities

A separate portion of the online survey administered to PSSs assessed activities they performed in their role as *peers*, that is, trusted members of a unique community capable of developing relationships and providing social and perhaps emotional support and guidance (*Appendix B, Table 3*). The activities PSSs *most often* reported conducting included “referring clients to appropriate services”, “assisting clients with immediate physical needs”, and “assisting clients with transportation needs.” The activities PSSs *least often* reported performing in their role included “facilitating or instructing support groups”, “supporting clients with career/education goals,” and “supporting clients with self-identified recovery goals”, although one of the four PSSs still reported performing each of the latter two activities “very often.”

Information gathered during the PSS interviews further illustrated the distinction they recognized between their roles at the library (a nontraditional setting for Peer Support Specialists) and more traditional PSSs roles. One PSS commented that “I love interacting with customers, although we don’t really get the opportunity to provide continuous support services in the traditional PSS job duties.” Another said, “I’m a navigator...I give [people] information on local resources. It’s rare that I see a client more than once or twice, so self-directed recovery goals are rarely talked about”.

## Professional Support and Outlook

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*I don’t think you could do this particular job for more than 3 months if you didn’t have supervision – like support, and debriefing and analyzing the situation.*

- Peer Support Specialist at DPL

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## Social Workers

PSSs identified DPL’s two social workers as the most important sources of their professional support. Knowing that a clinically trained social worker is always available to handle a crisis or other difficult situation (e.g. one involving children, domestic violence, suicide) is a critical component of the PSSs’ satisfaction with their work.

## Peers

PSSs also reported the support they receive from one another as being highly valuable. As an example, working within a team gives them the option of occasionally referring customers to a different PSS who may have had similar life experiences as the customer.

## External Support

Peer Support Specialists receive additional support from other community agencies. As previously mentioned, PSSs participate in weekly group supervision with a staff member at CMWN. PSSs also developed working relationships with people at non-profit organizations, which facilitates referrals for their customers. PSSs report that they are treated with respect by professionals in other settings, and that people (especially those working at non-profit organizations) are becoming increasingly aware of the PSS role. One PSS commented, “When I explain that I am a [PSS], almost all of them now know what that means.”

## Security Department

According to key personnel at DPL, a more compassionate model of rule enforcement—one that prioritizes respect and dignity, de-escalation, and potential reinstatement of privileges after suspension—resulted in a more positive library environment. This security model is aligned with the goals of the “It Takes a Library” pilot program, and the 25-member security department of DPL serves as another important source of support for PSSs. In addition to creating a safe environment for customers and library staff, all security personnel are trained to work with the social workers and PSSs. Most of the time, that means creating a non-threatening space for PSSs to work with customers, while being available to step in if necessary.

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*The security [at DPL] is phenomenal. ... I feel like if anything happened here, I know I would be safe. I am not afraid to interact with anybody... This is [a] very safe, very controlled environment. I have just been really impressed with them because they care.*

- Peer Support Specialist at DPL

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### **PSS Survey Data**

A portion of the online survey administered to the Peer Support Specialists at DPL assessed how supported and respected they felt by various individuals with whom they interact professionally. PSSs were asked to “Please indicate the extent to which you agree or disagree with the following statements.” PSSs reported feeling understood, valued, respected, and supported by supervisors, coworkers, and DPL as a whole. (*Appendix B, Table 4*). Additionally, PSSs were asked one question assessing overall satisfaction: “How personally satisfied are you with your current position as a PSS?” Among the four DPL PSSs, responses ranged from “Extremely satisfied” to “Somewhat dissatisfied.”

Five survey questions assessed the PSSs’ professional outlook (*Appendix B, Table 5*). All four PSSs agreed that their work as a PSS was providing valuable experience, skills, and training opportunities, as well as making them more attractive as candidates for future employment opportunities. However, PSSs were divided on whether they could “make a living as a PSS.”

Additionally, PSSs were asked one question assessing their thoughts on their future in this role: “How likely is it that you will still be employed or volunteering as a PSS one year from now?” Three DPL PSSs responded, “Extremely likely” and one responded, “Neither likely nor unlikely.”

### *Recovery and Wellness*

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*The way we can help people really adds to my self-esteem and my self-worth and gives me fulfillment and makes me happy.*

- Peer Support Specialist at DPL

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Very little research has examined whether working as a Peer Support Specialist may influence peers’ own wellness and recovery in both positive and negative ways. As the quote above suggests, meaningful employment can be a source of great personal satisfaction and fulfillment. As well, it provides financial empowerment and self-sufficiency. However, the increasing understanding and prevalence of ‘compassion fatigue’ among those in helping professions is receiving more attention. Compassion fatigue occurs when those who work directly with people experience burnout and/or secondary traumatic stress. It is reasonable to consider whether PSSs are at an increased risk for compassion fatigue, given the emotionally draining nature of their work, and the hopelessness and despair of some of their clients. Moreover, peers in recovery (by definition) bring their own lived experiences to interactions with their clients, potentially increasing the risk of secondary traumatic stress.

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*The hardest part of my job is really seeing people that are suffering, and [sometimes] there is nothing I can do for them.*

- Peer Support Specialist at DPL

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The Professional Quality of Life Scale (PROQOL; See *Appendix G*) is designed to assess compassion satisfaction and compassion fatigue. To begin to increase knowledge around the professional experiences of PSSs and their occupational wellness, we included the PROQOL as part of our online Peer Support Specialist Survey. The PROQOL measures three separate dimensions: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress, and it can be used to examine changes in these dimensions over time. Survey respondents receive a score on each scale.

*Compassion Satisfaction* refers to a person's satisfaction with their ability to be an effective caregiver. Two out of four PSSs at DPL scored in the top quartile of people who have responded to the survey, indicating they have a "high" degree of compassion satisfaction. The other two PSSs scored an "average" level of compassion satisfaction (i.e. in the middle 50% of individuals). *Burnout* refers to feelings of hopelessness at being effective in one's job or making a difference. Three out of four PSSs scored in the bottom quartile of people, indicating a

"low" degree of burnout. One PSS reported an "average" degree of burnout. Finally, *Secondary Traumatic Stress* can occur when a person cares for those who have experienced extremely or traumatically stressful events. Again, three out of four PSSs reported a "low" degree of secondary trauma, while the fourth reported an "average" degree of secondary trauma.

These results are encouraging, and they likely reflect a thoughtful hiring process combined with a highly supportive environment both at the library and CMWN, as well as a tiered system in which social workers (rather than the PSSs) frequently handle crisis situations.

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*If you aren't feeling well and you need a mental health day, we have a great staff, team, and management that makes it work.*

- Peer Support Specialist at DPL

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## Customer Connections: By the Numbers

At the beginning of this pilot program, the Peer Support Specialists and social workers implemented a detailed tracking system for all types of customer contacts at the library. Following consultation with the evaluation team at BHWP, PSSs and social workers began documenting contacts and services provided in a manner that would meet two key goals: (1) maintain the privacy and trust of customers receiving services, and (2) collect adequate information to facilitate tracking of the volume (e.g., number of contacts per month, number of individuals served) and breadth (e.g., mental health, housing) of customer needs that are being addressed through the project.

To that end, staff record first name, month and day (but not year) of birth, and category(ies) of needs served. Provision of first name and date of birth are not required in order to receive assistance, but they are encouraged so that project staff can evaluate the proportion of individuals who are *single contact* customers and the proportion who are *repeat contacts*, returning to the library for ongoing support and follow-up. Social workers and PSSs also note any agency contacts with which they are collaborating (referring, consulting, etc.) to help meet the needs of the individual. Detailed notes regarding the context or special circumstances of the contact are also typically recorded in the customer tracking records.

Program personnel spent several months developing and fine-tuning a system of data collection that would generate useful information for stakeholders, while minimizing burden on social workers and PSSs. Over the course of the project, the quality of the data being collected from library customers noticeably improved, possibly because PSSs and social workers became more familiar with the information being collected, and possibly because library customers became increasingly trusting of the staff over time, making it more likely that they would feel comfortable divulging personal information. Because data collection protocols were not consistently established for the first few months of the project, we report results from data collected over the past year, July 2017 – May 2018 (See *Appendix E*).

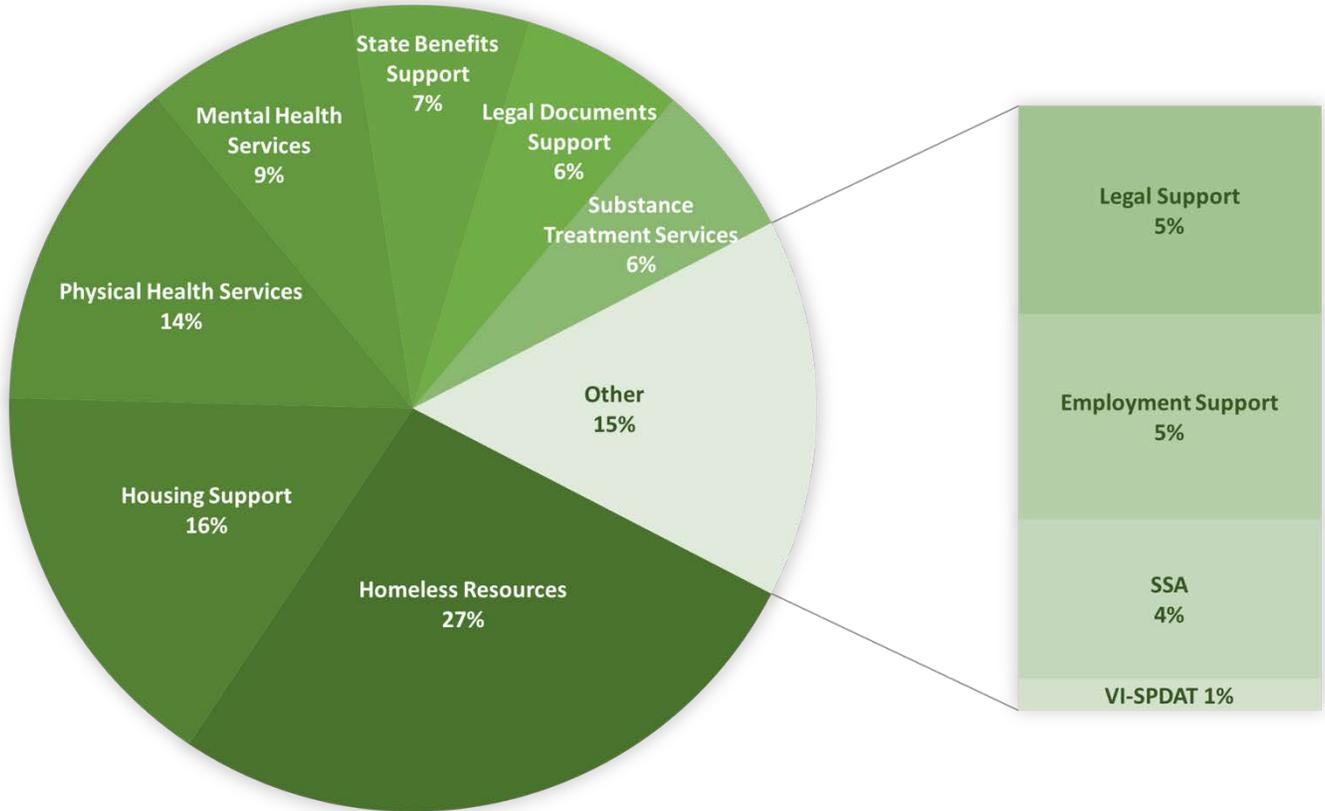
Over the past eleven months, social workers and PSSs have made 2,864 contacts with customers at the Denver Public Library. To generate an estimate of the percentage of repeat vs unique customers who received services from social workers or PSSs, we examined those records which contain some means of customer identification (69% of total records). We identified 314 customers (28% of the sample) as being “repeat” customers; that is, they visited the social workers and/or PSSs at DPL multiple times throughout the year. Although they comprised only 28% of the sample, these repeat customers accounted for 60% of all customer contacts (1193 customer contacts) over the course of the year. The sample also contained 793 unique individuals who could not be identified as having returned to the library multiple times based on the information they were willing to provide. The total number of unique customers identified during this time was 1107. However, if everyone had provided identifying information, we estimate the actual figure at closer to 1600 unique individuals receiving support services at DPL over the 11-month period.

Figure 4 depicts the distribution of the types of services provided by PSSs over the data collection period. Although PSSs often addressed multiple needs of customers in a single contact, this figure represents the percentage of all services provided that fall into a particular category. Generally, providing resources for individuals experiencing homelessness and offering housing support, together, made up more than half of all the services provided. Substance treatment, and physical and mental health services, support, and referrals, along with substance treatment support and referrals made up nearly another third of the services provided to DPL patrons.

**28%**

of individuals PSSs contacted  
accounted for 60% of total  
customer contacts.

## Distribution of Services Provided



**Figure 4: Distribution of services provided.** Percentages refer to the percentage of all provided services (N = 5585) that fall into particular categories. Note: These percentages differ from those presented in Appendix E, which displays the percentage of customer contacts during which a particular service was provided.



## Library Impact

To evaluate the impact of the “It Takes a Library” pilot program at DPL, a brief survey was administered to DPL staff members across various library departments approximately one year after the program launched. The survey was completed by 34 staff members, and survey responses were received directly by the independent evaluator, BHWP. (The survey is found in *Appendix C* and responses are summarized in *Appendices D*.)

### Changing Library Dynamics

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*It was kind of like the Wild West ... we were handcuffing people 4 or 5 times per week. We set out to change a culture.*

- Security Manager at DPL on the culture when he was hired 5 years ago

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Together, the social work and Peer Support Specialist programs at DPL have galvanized a deliberate shift in the library’s culture of community. This shift is evident at multiple levels of the library community, from senior leadership and city stakeholders, to library staff, customers, and the surrounding public.

The presence of PSSs and social workers at the library has propelled this shift in dynamics because individuals within the target population greatly value services provided by the PSSs. This appreciation encourages people to follow the rules of the library so that they can return and stay for longer periods of time and access the services, resources, and physical safety of the library. Security personnel are trained to give social workers and PSSs latitude and space to create relationships and deescalate situations before getting involved themselves.

Four survey items completed by library staff assessed changing library dynamics as a result of the pilot program. (*Appendix D, Table 6*)

Staff reported that PSSs:

- Contributed to a reduction in behavioral issues
- Reduced incidents requiring security involvement
- created a more positive environment
- improved workplace dynamics

Illustrative quotes:

*“The [PSSs] help de-escalate and [they] are kind to customers.”*

- Library Shelver at DPL

*“The issues at hand were always handled professionally and in a way that seemed to make the troubled person feel calmer and open to suggestions. I am proud to tell people I work for an organization that is taking such a positive step towards helping people solve their problems, as opposed to just making the people go away.”*

- Librarian at DPL

### Increasing Staff Capacity

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*Librarians really want to help people, but when the questions are, ‘How do I get to substance treatment?’ and [the librarians] don’t have that training? It’s hard.*

- Social Worker at DPL

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Over the past several years, librarians at DPL (as in most major cities) are increasingly called on to answer questions about community resources, social services, and healthcare options. Without adequate training, they feel underequipped to provide this information and support. The social work and Peer Support Specialist programs have given DPL staff an invaluable referral resource.

Every department of the library benefits. In the Community Technology Center, people often need assistance not only with the technology itself, but with the content of what they are working on (e.g. filing a police report, applying for food assistance). Helping individuals at this level goes beyond the

skill sets of staff trained in technology, so technology center staff now refer customers to the PSSs for help with content. This reduces frustration on the part of the customers and allows technology staff to focus on helping individuals develop their technology skills.

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*I've come from libraries that don't have this, and the level of work we're able to do here is so much higher because we have this resource.*

- Community Technology Center Manager at DPL

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Three survey items completed by library staff assessed how the "It Takes a Library" pilot program has impacted their own roles and the value to the library staff (*Appendix D, Table 7*).

Staff reported that the PSSs:

- Allowed library staff to focus more time on their own library work
- Served as a referral resource for library staff
- Are a valuable addition to the library staff

Illustrative quotes:

*"At my first 'coffee and connections' event, a Peer [Support Specialist] gave me tips and encouragement that led to wonderful interactions with the customers. Without his help, I wouldn't have been sure about the best approach."*

- Business Reference Collection Specialist at DPL

*"I completely support the [PSS] program 100%. They are a phenomenal, invaluable resource, and I am incredibly pleased to have their assistance. Hire more!!!"*

- Shelver at DPL

## *Modeling Recovery*

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*The peers role-model for the rest of the staff that it's OK to get to know somebody, to humanize people, and that's huge. For the community, that ripples out.*

- Social Worker at DPL

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Not only do PSSs model recovery for the customers they work with directly, but the presence of PSSs serves as a reminder for the rest of the staff that recovery is possible, and that people in challenging circumstances can and do get better. In this way, the program helps to combat the compassion fatigue of library staff, who otherwise may lose hope. Staff are grateful for the opportunity to witness connections formed with PSSs and the benefits of those connections.

Both the DPL security staff and the Community Technology Center staff engage regularly with the social workers and PSSs, which has served to expand staff members' capacity and skill to work effectively with the target population. Social workers attend all security department staff meetings, and technology center staff shadow Peer Support Specialists on a regular basis.

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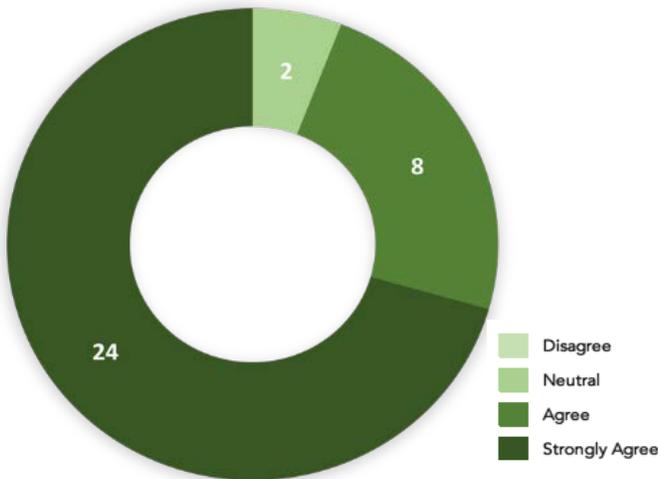
*I wanted my team to be able to learn things and see the behaviors that professional social workers [and peers] do to calm down a situation.*

- Community Technology Center Manager at DPL

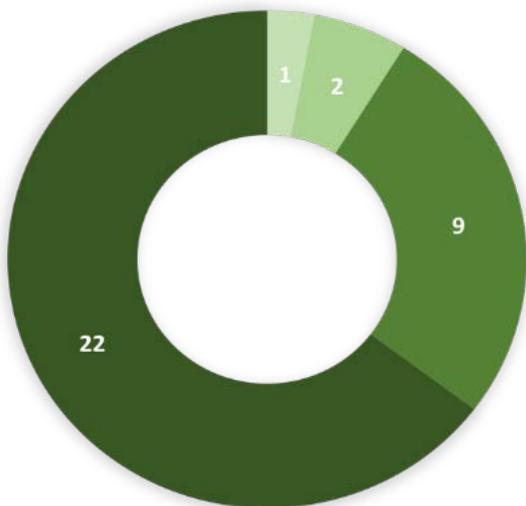
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Two survey items completed by library staff assessed how the “It Takes a Library” pilot program has helped to model recovery for library customers and staff (*Appendix C, Table 8*). Again, respondents were asked to “Indicate the extent to which you agree or disagree with each of the following statements.” Staff overwhelmingly reported believing that PSSs were able to model recovery for patrons (94%) and staff (91%) alike (*Figure 5*).

Sometimes, peers can be more effective than other professionals in supporting vulnerable customers because they have experienced what people are going through.



Watching PSS working with people in the library helps to remind the staff that recovery is possible, even for people going through really hard times.



**Figure 5: DPL staff perceptions of PSSs ability to model recovery** (N = 34). Numbers refer to the number of survey respondents who selected each response option.

Illustrative quotes from survey respondents include:

*“The Peer [Support Specialists] are invaluable. They form connections with customers and their visibility, along with continued conversations with customers they recognize, remind both library staff and customers that everyone is a human being deserving of your time and consideration.”*

- Librarian at DPL

*“[PSSs] provide a great service to our customers with challenges – they are not only empathetic but offer potential solutions to help them get [the] assistance they need or to help themselves. The [PSSs] are positive role models who assist without judgement. We’re lucky to have them and more would be better!”*

- Shelver at DPL

### Program Expansion

*We could have 5 times as many Peer [Support Specialists] and [they would] still have work.*

- Community Technology Center Manager at DPL

The initial goal of this program was to expand it across multiple branches within the DPL system. Staff were asked two questions regarding expansion. (*Appendix C, Table 9*). Nearly every staff member surveyed (32 of 34) “agreed” or “strongly agreed” that the PSS program should be expanded to other library branches in Denver. While other branches had a clear need, and although there is desire to expand, capacity issues have delayed expansion to date. Similarly, 29 of 34 survey respondents “agreed” or “strongly agreed” that DPL should hire more PSSs. Since these interviews were conducted, DPL has expanded drop-in hours at the main branch to include Sundays.

Illustrative quote from survey respondent:

*“The Peer [Support Specialists] we have on staff are warm, professional, and especially, helpful. I’d love to see the program expand.”*

- Librarian at DPL

# Successes and Challenges of “It Takes a Library”

## Successes

- The intent of the “It Takes a Library” pilot program was in part to demonstrate value of adding PSSs to library staffing teams in order to serve the needs of some of the city’s most at-risk individuals. Outcomes of the program made this case, resulting in funding being provided by the City and County of Denver to continue these positions as the pilot phase ended. By creating permanent positions funded through the city, job security for PSSs is strengthened.
- Since the program began, library staff have grown accustomed to the presence of PSSs and learned more about their roles. Today, the vast majority of the staff are highly supportive of the program, often commenting that the program should be expanded.
- Developing enough trust among individuals from the priority population to allow PSSs and social workers to collect basic data for evaluation purposes was a significant success of this program. As trust of the PSSs increased over time, there was a notable improvement in the quality of data collected.

## Challenges

- Despite the comprehensive training received by PSSs and the support offered by CMWN, both the PSSs and social workers felt that nothing could truly have prepared the peers for their role at DPL. One social worker commented, “Peers who hadn’t experienced homelessness themselves in Denver were shocked at the depth of the pain and trauma that happens in the homeless community.”

- Within the library itself, the process of educating the staff about the role of a PSS has taken time. As one PSS stated, “When we first came in, the library staff was shell shocked from the previous years [of the expanding opioid epidemic] and with this whole program being started, I think for some of them it took some time. It's definitely a change, and change is hard.”
- For most of their time at DPL, the PSSs were highly concerned about future availability of funding for their positions, in part to due to the loss of one source of grant funding. For peers with lived experiences of homelessness, job security is of vital importance. Concerns over funding are thus a significant barrier to occupational well-being for many Peer Support Specialists, and it can be difficult retaining peers in this situation.

## Lessons Learned

What follows are a set of recommendations for those who are considering deploying a similar program elsewhere or expanding existing programs. These recommendations are synthesized from key informant interviews with program staff from DPL and two similar programs in other cities (San Francisco and Chicago-area), the DPL PSS and staff surveys, as well as from the evaluation team's work with CMWN, DHS, and OBH over the course of the project.

It is worth noting that not every lesson learned is done so through failure or overcoming unexpected obstacles. DPL and CMWN staff came to the program with transferable knowledge and skills from other projects. Moreover, while the DPL program is pioneering in many respects, previous successful programs were available to serve as models to expand upon. Therefore, many of the recommendations here were extracted from what went right from the beginning.

### *Start with a Firm Foundation*

Unlike the two other national programs interviewed for this evaluation, the culture change reinforced via the “It Takes a Library” program was already underway—preceded, in part, by a more compassionate security methodology. This realignment of security operations with the larger organizational value of providing respectful service to all patrons was compatible with the mission of the Recovery and Support Services Program to use the library as an access point to services.

By contrast, programs in San Francisco and Oak Park (Chicago-area) were started without a similar alignment of organizational values. Within these programs, it took considerably more time for PSSs to become accepted and integral members of the library teams. To achieve faster integration of PSSs, new programs may benefit from following rather than leading a culture change.

### *Reframe the Role of the Library and its Relationship to the Community*

Key staff members at DPL and the San Francisco and Oak Park libraries all reported having heard sentiments from librarians to the effect of “I’m a librarian, not a social worker” prior to implementing their peer programs. To shift this perspective requires a conceptual reframing of the library’s primary task. The “traditional” library patron is often perceived to be in search of media, e.g., a book or a film. Reframing the patron’s search in terms of the information, knowledge, skills, (i.e., *the resources*) housed within that media permits library staff to think of the priority population’s needs as equal to that of the traditional patron. Library staff already provide, for example, classes on resume building.

### *Highlight how PSSs Relieve Staff Burden*

Even if it were widely agreed that libraries should provide navigation and referral services for individuals experiencing homelessness, it may remain the case that resistance persists due to concerns over whether learning these new tasks would create workplace inefficiencies. That is, would providing the specific services to individuals experiencing homelessness detract from the services libraries were originally created to provide?

The DPL pilot program clearly alleviated some of these concerns through the use of PSSs—individuals with lived experiences, most of whom understand both what homelessness is like as well as what resources are needed and where to find them.

### *Establish a Relationship with Library Security*

Due to the characteristics and unique challenges of the priority population, and due to the stigma they face which may increase the scrutiny from other patrons, social workers and PSS’s housed in libraries must develop a close working relationship with library security. Within all three libraries interviewed for the current evaluation, the roles of social workers, PSSs, and the security personnel are clearly defined. Staff are trained to know when one or the other is appropriate for any given situation. This protects professional boundaries of team members, better preserves the relationship between the peer and the patrons, and better respects the dignity of the patron.

### *Ensure PSSs are Consistently Visible throughout the Library*

Both social workers agreed during key informant interviews that ensuring library staff are “on board” with having PSSs is well worth the effort. When the pilot program first began, library staff needed training on how to utilize the PSS appropriately. By working to make sure PSSs were consistently visible on the floors of the library, PSSs could demonstrate to other staff members when they were the best qualified and when other departments or personnel were better suited.

### *Management, Supervision, and Staff Support Must be Trauma-Informed*

The role of trauma among individuals who are experiencing homelessness is complex. Utilizing peers who have been members of this community has amazing potential benefits, but is not without challenges. Managers, supervisors, and coworkers should all be trained in the foundations of trauma-informed care. Some of the trauma-informed support the PSSs’ supervisors may use are: (1) providing PSSs time and space to collect themselves after intense interactions with patrons, (2) daily

check ins, (3) individual supervision, and (4) part-time positions, all of which were considered important to the success of the current program at DPL.

The interviewed programs in Chicago and Oak Park did not make particular mention of a “trauma-informed” management style, but their PSSs were employed part-time. And while unspoken, concepts of trauma-informed management did emerge. For example, when asked what might improve their program, “higher pay” for the PSSs was brought up—not just to improve the financial quality of life a peer might experience with a higher wage, but because a higher wage signals a higher value—a concept with more salience to somebody who feels they are perceived as “just a peer.” This is a particular problem in San Francisco where many of the PSSs are still in transitional housing and thus may be stigmatized precisely the way the patrons are.

### *Program Evaluation Develops Deliberately*

Collecting data from populations that suffer social stigma and are often justice-involved requires delicacy and trust. Considerable time and effort went into developing an evaluation framework that was feasible at DPL. Similarly, collecting data on outcomes related to recovery and wellness among PSSs themselves was also an evolution, as these efforts were initially resisted by partner agencies for fear that asking peer employees about their wellness would be viewed as “stigmatizing.” Developing measures that all program partners are comfortable administering is an iterative process.

### *Be Strategic with External Partnerships*

The needs of the priority population are significant and diverse. That is, these individuals require a variety of types of services and many of them need to be delivered with greater intensity. The potential avenues for broadening the scope of services provided are practically unlimited. Therefore, having a specific focus for how and why such partnerships should be formed remains critical. At the same time, providing a robust set of services is important for establishing a reputation as a trusted and knowledgeable resource.

For example, DPL has partnered with a mobile laundry service to address a basic need within this

population. In Oak Park, in addition to their Social Services Specialist program, they have a companion youth-focused program. These are complementary services that are able to build off one another. And in San Francisco, the peers are trained to educate individuals who are newly experiencing homelessness on the reality of the housing situation in that area. Those who initially expect to get housing in the area quickly may be persuaded to avail themselves of personal resources in other cities. If this is a possibility, they are connected to Homeward Bound—a service that provides one-way bus tickets to connect individuals with helpful friends or family members elsewhere.

### *Anticipate Varied Reactions from the Community*

Establishing community “buy-in” was difficult in some instances. The PDL program received significant attention from the public and local press. While much of the press coverage was positive, some coverage seemed to conclude that persons who were experiencing homelessness were coming to DPL due to the program, rather than conclude that the project was responding to a population that had long seen the library as a haven.

There is no denying that people experiencing homelessness, mental health conditions, and substance use are all stigmatized. Services helping such individuals are often perceived as enabling homelessness and/or substance use. Such reactions and accompanying pressure to roll back or eliminate such a program should be anticipated. Those on whom pressure may be focused (e.g., elected officials, library leadership) should be prepared and equipped with talking points. Proactive communications disseminated to the public might highlight that such services primarily serve those who are already in communities and that they are a stabilizing force. Importantly, PSSs, social workers, and library staff members at DPL (including those from the security department) overwhelmingly reported that the presence of social workers and PSSs had not increased negative incidents at the library, nor had this program served to increase the number of persons from the target population coming to the library for resources and security.

It is also true that much of the commentary from the surrounding public will be positive. Be sure to capture and amplify those voices that support the program.

### *Continuing Education is Desired and Required*

As has already been noted, even after receiving 80+ hours of training, at the end of the program evaluation period DPL PSSs expressed a desire for additional training on topics already covered, as well as training on new topics they perceive as being important to their professional development in their current role. Skills take time to develop, and revisiting fundamental trainings periodically after PSSs have more experience in their work context is advantageous.

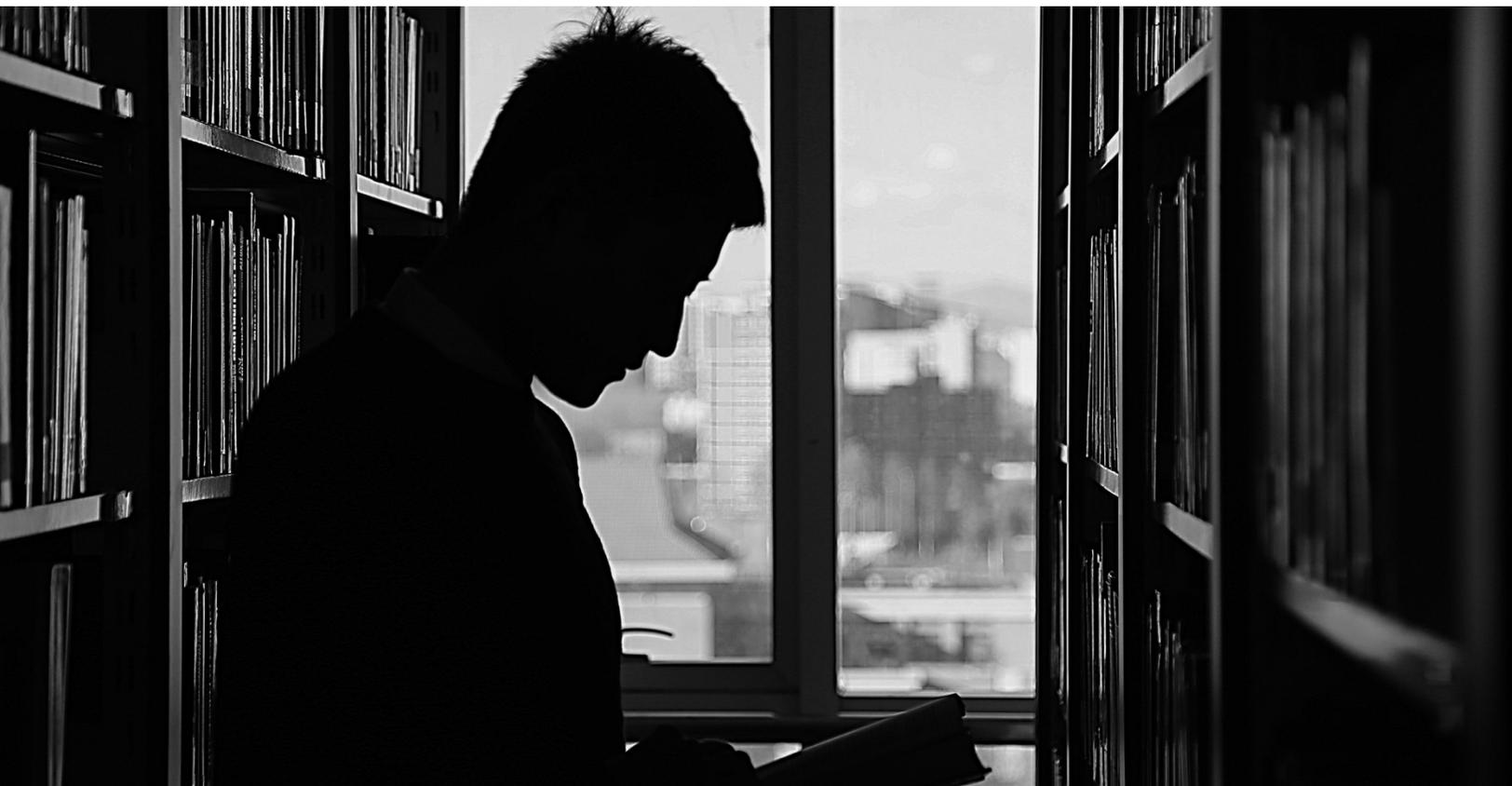
### *Staff Turnover is Inevitable*

The “It Takes a Library” pilot program has benefitted from a stable social work and PSS staff over the past 18 months. However, all programs that run long enough will suffer from the loss of key personnel. Staffing churn should be anticipated and

prepared for. Policies, procedures, roles and responsibilities, reporting structures, program goals and objectives, and strategies and tactics should all be part of a formalized process including written materials and standardized onboarding procedures. The impacts of staff turnover can be mitigated further through ongoing co-training.

### *Strive to Create Permanently Funded PSS Positions*

It is difficult to ensure job security among grant-funded employees. High turnover may be of particular relevance for PSSs operating in non-traditional settings, where peer programs are both novel and often implemented through “soft” funding. Transitioning from soft money such as grant funding to permanently funded positions should always be a goal for PSS programs. As the “It Takes a Library” pilot program has demonstrated, this can be an achievable outcome.



## Part II — Wellness Recovery Action Planning (WRAP®)

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*Clear, simple tasks to obtain optimal wellness. I like the self-awareness and reflection needed to create a plan.*

- WRAP® Workshop Participant

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### Introduction to WRAP®

The Wellness Recovery Action Plan (WRAP®) is a personalized wellness and recovery system born out of and rooted in the principles of self-determination, personal responsibility, empowerment, and self-advocacy. The Wellness Recovery Action Plan was developed by Mary Ellen Copeland, PhD. The Copeland Center for Wellness & Recovery provides WRAP® Facilitator Training and promotes the key standards of the WRAP® program.

WRAP® is a wellness and recovery approach that helps people to: 1) decrease and prevent troubling feelings and behaviors; 2) increase personal empowerment; 3) improve quality of life; and 4) achieve life goals. Individuals learn to use WRAP® through a peer-led group process. Formal WRAP® Workshops are led by two trained facilitators – peers who use WRAP® for their own recovery. Information is delivered and skills are developed through a variety of interactive discussions and individual and group exercises. Key WRAP® concepts and values are illustrated through examples from the lives of the facilitators and participants. WRAP® participants create a personalized recovery system of wellness tools and action plans to achieve a self-directed wellness vision despite life’s daily challenges.

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*As valuable as the WRAP® concept is, you enhanced its meaning to us by personalizing it [and] asking us to provide our own examples.*

- WRAP® Workshop Participant

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Researchers have demonstrated positive behavioral health outcomes for individuals with severe and persistent mental health challenges who participated in peer-led WRAP® groups. In 2010, WRAP® was recognized by SAMHSA as an evidence-based practice.

Although WRAP® was originally developed for use with people who experience mental health challenges, the plan can be used by anyone who wants to effectively manage certain aspects of their lives. These could include physical health conditions, substance use, trauma, daily stress, and major life changes, among others.

A key component of the Recovery and Support Services Program was to expand the use of WRAP® across both service providers and individuals within the target population. Although “service providers” and “members of the target population” are described as independent groups, it is important to acknowledge the overlapping challenges faced by service providers and individuals. Many of the individuals providing services are, themselves, members of the target population insofar as they frequently report having personal experiences with mental health challenges, substance use, homelessness, and/or varying degrees of justice involvement. Moreover, WRAP® is an effective tool for managing occupational stress for those working within helping professions that have historically been known to cause “burnout” among employees.

## Expanding WRAP® among Service Providers

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*I learned to reflect more often around my compassion fatigue [and] how to recognize warning signs that I am not practicing enough self-care.*

- Denver Human Services Professional and WRAP® Workshop Participant

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Gaining increased access to the priority population involved creating a strategic, dedicated plan to develop relationships with leaders and providers at agencies serving at-risk clients. A first step toward increasing the number of at-risk clients who have created a WRAP® was to increase understanding among service providers of the value of WRAP® as a recovery and prevention strategy. Over the first 18 months of the project, staff members from DHS and CMWN who are Copeland Center Advanced Certified WRAP® Facilitators conducted multiple, one-hour WRAP® Overview Workshops for the purpose of introducing service professionals to WRAP®'s evidence base, 5 key concepts, and potential uses for service recipients. In total, 316 social service professionals were introduced to WRAP® and received promotional materials for upcoming workshops. Participants were employees from various departments within DHS, counselors with mental health centers, Peer Support Specialist trainees, and graduate level social work students.

## Expanding WRAP® among the Target Population

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*I learned that I can take personal responsibility using WRAP®, and sometimes I'll choose not-so healthy thoughts and behaviors and sometimes I will choose more healthy thoughts and behaviors.*

- WRAP® Workshop Participant

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Among the target population, two types of WRAP® Workshops were conducted: WRAP® “promotional” sessions, designed to introduce WRAP® and spark interest from potential participants in planning for future WRAP® Workshops, and co-facilitated WRAP® Workshops in which participants are given the tools and strategies to develop their own personalized WRAP®. So far, promotional sessions have been attended by 98 individuals, and facilitated WRAP® Workshops have been attended by 83 individuals within the target population. Participants have been recruited and/or referred from DPL, local detention centers (e.g. D Pod and CHANGE programs), probation and parole programs (e.g. PHASE), local behavioral healthcare agencies (e.g. Mile High Behavioral Health), CMWN, and day programs serving individuals experiencing homelessness (e.g. St. Francis Center) in the Denver area.

## WRAP® Evaluation

### Demographics

For members of the target population, demographic forms now administered during all co-facilitated WRAP® Workshops track gender, age, and race/ethnicity; employment and insurance status; and personal experience with mental health and/or substance use conditions, homelessness, and the justice system. (See *Appendix H* for initial demographic data from 30 individuals in the target population collected since March of 2018).

Two-thirds of participants from the target population were women and a majority (69%) identified their racial/ethnic group as non-Hispanic Caucasian. Nearly two-thirds of the sample reported an annual household income below \$20,000, and three-quarters reported Medicaid as their source of health insurance. Fewer than half of survey respondents had full or part time employment. Almost 90% of participants responded that they have personal experience with mental health conditions, substance use conditions, or both. Reports of having experienced some form of victimization (e.g., domestic violence, stalking, or sexual assault) was also common among participants. Nearly half had experienced domestic

violence, over 40% had experienced sexual assault, and just over a quarter had experienced stalking. One in five survey respondents reported that they were currently experiencing homelessness or risk for homelessness, and a quarter reported current involvement with the criminal justice system.

## Resiliency and Coping Self-Efficacy

Although WRAP® has demonstrated efficacy for helping persons with mental health conditions, its efficacy within other at-risk populations is not as well-established. The current project offered an opportunity to collect information from a diverse group of WRAP® participants using standardized measures of resiliency and self-efficacy (The Brief Resiliency Scale [BRS; Smith et al., 2008] and The Coping Self-Efficacy Scale [CSES; Chesney et al., 2006]), *Appendix I*). Baseline data are available from the same 30 individuals described above, all of whom attended the first session of a WRAP® Workshop. Thus, participant responses reflect self-reported resiliency and coping efficacy *before* they experienced a WRAP® intervention.

The BRS consists of six items that assess the ability of individuals to “bounce back” from adverse experiences. The possible scores on the BRS range from 1 to 5, with 1 indicating very low resilience, and 5 indicating very high resilience. In one study with a mix of 844 participants who were either healthy or suffering from various health conditions, the average score on the BRS was 3.7 (Smith et al., 2013). By comparison, the average baseline score for our WRAP® Workshop participants was just below 3.0, which falls into the category of “low resilience.” Scores ranged from 1.3 to 3.7, indicating that not a single participant reported “high” levels of resilience at baseline, although some did report “average” levels of resilience.

The CSES consists of 26 items that assess an individual’s confidence to carry out three central types of coping strategies: problem-focused coping, emotion-focused coping, and social support. Possible scores on the scale range from 0 to 260, with higher scores indicating greater confidence at implementing coping strategies. In one study of depressed, gay men living with HIV, baseline scores on the CSES (prior to a coping intervention) ranged from 140 to 148. The average baseline score for our WRAP® Workshop participants was similar: 156.

However, scores among our sample varied widely, ranging from 61 to 243.

The most useful aspect of administering the BRS and the CSES will be to compare baseline scores with those obtained *after* completing the WRAP® interventions, in order to investigate whether WRAP® increases resiliency and coping self-efficacy among this diverse, high priority population. To this end, baseline *and* follow-up assessments of all WRAP® Workshop participants are encouraged.

## Workshop/Presentation Satisfaction

All participants are asked to share their perspectives on the quality of the WRAP® tools and presentation. Satisfaction data are available from all participants, including providers, and are presented in *Appendix H*. Overwhelmingly, participants were satisfied with WRAP® presentations and workshops: the overall satisfaction score across all workshops and participants was 4.5 out of a possible 5.

## Future Evaluation Planning

To assist with long-term follow up of WRAP® participants, project partners collaborated on developing a [comprehensive evaluation tool](#) designed to be administered online. The intent of the survey is to allow researchers and practitioners to collect new information about the efficacy of WRAP®, while simultaneously engaging former WRAP® participants on an ongoing basis. The tool contains the BRS and CSES scales, as well as additional information about the utility of the WRAP® concepts and materials. Data collected from this tool will contribute to the knowledge base around WRAP® as an intervention with broad applicability and efficacy, and such knowledge will help to generate discussion and investment in future funding for integrating WRAP® into city programming.

# Successes and Challenges with Expanding the Use of WRAP®

## Successes

- Social service professionals demonstrated an appreciation for recovery perspectives and interest in recovery tools, including WRAP® – particularly as a secular path to recovery from substance use.
- Social service professionals are interested in creating WRAP®s for their own self-care and resilience to secondary trauma.

## Challenges

- Although there is considerable support for peer-delivered services (including WRAP®) at leadership levels and by individuals seeking services, social service providers appeared to be somewhat less supportive of these interventions - some expressed skepticism about the value of WRAP® and peer support services. Despite multiple presentations to providers over several months, very few endorsed WRAP® or referred clients to scheduled WRAP® Workshops.
- Currently, there are only a few independent WRAP® Facilitators and two Advanced-Level WRAP® Facilitators in the state of Colorado, who work for various agencies. Given that WRAP® is a co-facilitated group process, it is difficult to offer WRAP® programs without effective collaborative efforts across agencies.
- Misinformation about WRAP® and peer-delivered services was evident among some service providers who attended overview sessions. For example, some providers mistakenly thought that individuals must be at a certain point in their treatment to benefit from WRAP® and that this is decided by their providers. In fact, individuals can benefit from WRAP® at any stage of their treatment or recovery. As well, some providers thought that action plans are best created during one-on-one sessions between clients and

providers. However, a critical component of WRAP® is the participation in a peer group process with trained co-facilitators.

- It is difficult for peers in recovery who have been justice-involved to offer services in certain contexts, as safety concerns by law enforcement limits access of these peers to the individuals who could most benefit from their services (e.g. individuals involved with the criminal justice system).

## Lessons Learned

- Expertise in WRAP® is essential for developing metrics and implementing the model successfully across a variety of settings.
- DPL was not the best venue for WRAP® Workshops for the target population. Clients served at DPL were not generally able to participate in a multi-session Workshop that is scheduled at regular intervals. Agencies and organizations that engage with clients on a more regular basis are preferred venues.
- Significant investments of time are required for outreach to providers and to develop supportive relationships.
- Support and education by leadership at the state and municipal levels might encourage service providers in the behavioral health system to feel more comfortable with WRAP® and peer support services. Information about the WRAP® group process, local outcomes, and benefits to systems of care is needed for buy-in from many providers.
- A survey of providers might yield useful information about sources of concern regarding peer support services and opportunities for education and engagement.
- To continue expanding WRAP® services, leadership, particularly from peer-run organizations such as CMWN, is needed to increase the WRAP® Facilitator workforce. Facilitator Trainings and associated prerequisites should be planned in collaboration with agencies, departments and organizations interested in offering WRAP® groups. Participants of services who use WRAP® should continue to be recruited.

- More progress is needed in demonstrating reduced service utilization and criminal justice recidivism through better tracking of WRAP® trainees – particularly those recruited and referred from correctional programs. Effective tracking and data collection will require the development of collaborative relationships across multiple agencies and stakeholders, specifically including correctional agencies, and dedicated time to allow individuals to participate in these programmatic efforts.

- Systems of service remain siloed and fragmented, which creates challenges for a continuum of peer delivered supports. Systems would benefit from alignment with a recovery and rehabilitation orientation.

WRAP® has demonstrable national outcomes, particularly for the behavioral health population. While there were challenges to implementing WRAP® as a core component of this program, by proactively working with providers and agency leadership, WRAP® can be an important recovery tool that peer programming can support and navigate at-risk individuals toward these services.



# Part III — Overall Accomplishments, Lessons, and Conclusions

## Programmatic Accomplishments

- CWMN and DPL were able to demonstrate that a community institution such as a library could meet its historical mission while at the same time creating an innovative hub of care that helps serve the complex needs of individuals who utilize this community resource.
- While provider buy-in for WRAP® needs to be increased, the Recovery and Support Services Program provided a model for WRAP® services to be offered to multiple non-traditional populations, including but not limited to the populations experiencing behavioral health conditions, justice involvement, and homelessness or risk of homelessness.

## Evaluation Accomplishments

The following novel evaluation tools and strategies were successfully developed and/or identified:

- Follow-up evaluation tools for Peer Support Specialists, which contribute to the knowledge base around the experiences of PSSs, and whether those professional experiences impact peers' own wellness and recovery, as well as professional quality of life.
- Strategies for collecting tracking data at public libraries, which provides critical information for city planners and other stakeholders within leadership positions.
- Baseline and follow-up evaluation tools for WRAP® Workshop participants, which serve to both maintain long-term relationships with individuals from disenfranchised populations and to assess the degree to which WRAP® is useful and valuable for increasing wellness and recovery (specifically resiliency and coping self-efficacy).

## Lessons Learned

- **Develop realistic and sustainable outcomes.** Tracking recovery outcomes among individuals within priority populations who may engage systems of service at multiple entry points (such as community corrections) depends on linking data across multiple agencies. Establishing consistent participation and “buy-in” from individuals within each of those agencies to facilitate referrals, tracking, and other evaluation efforts served as a primary challenge for the current Program.
- **Clearly define and revisit program objectives, roles, and responsibilities.** This Program was a collaboration between agencies wherein different partners administered the project, executed day-to-day operations and services, and conducted program evaluation. Connection to the Denver corrections system was initially a key aim of this Program but did not materialize due to lack of participation by original key project partners. Additionally, there were multiple partner, staffing, and leadership changes throughout the project, including the executive director of the lead agency. This staffing turnover resulted in a lack of organizational memory, which, when combined with the absence of clearly written agreements between some partner agencies, led to misunderstandings regarding roles and responsibilities. These issues highlighted the need to be vigilant to detailed and mutually agreed to project documentation such as partnership meeting minutes and evolving scopes of work.

## Conclusions

Our nation's most vulnerable individuals often have limited access to healthcare and other needed resources. Persons who are experiencing homelessness or are at risk for homelessness typically have overlapping chronic health conditions, behavioral health conditions, and/or criminal justice involvement. Effectively reaching this population has been limited by mistrust of public systems and providers, transportation difficulties, cultural mismatches, and low health literacy, among other issues.

The Recovery Support Services Program demonstrated that individuals with a lived experience of homelessness, criminal justice involvement, and/or behavioral health conditions could effectively complement existing library staffing. Peer Support Specialists were able to build rapport with persons within the target population, provide brief services at the library, and navigate individuals to other needed services. Moreover, they could do so cost-effectively, and in a way that garnered support from other library staff. The Denver Public Library was a natural hub of community care that met individuals in a setting where they were already utilizing services. For many communities this might not be a library, but could be a range of other settings such as homeless shelters, community corrections programs, or integrated care clinics. But the findings might be largely generalizable across these settings. The Recovery Support Services Program also made significant progress in promoting the use of proven recovery supports such as WRAP® across service providers and the target population.

The Program is another practice-based demonstration that adds to the ever-expanding knowledge base surrounding the following overlapping areas: 1) PSSs are effective providers of important services to populations that more traditional types of professionals find hard to access; 2) the patient centered medical neighborhood model can be expanded outside the *medical* context to include any site as a hub of care in a "health neighborhood;" and 3) meeting individuals with complex needs at sites where they already are is a cost effective and efficient way to provide needed services in a non-restrictive, comfortable environment where guidance is more likely to be accepted and followed. This project's outcomes and lessons learned provide a high utility model for other agencies in Colorado and beyond who would like to maximize the power of peers.



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# Appendices

[Appendix A: Script for Key Informant Interviews at Public Libraries](#)

[Appendix B: Denver Public Library Peer Support Specialist Survey and Response Tables](#)

[Appendix C: Denver Public Library Staff Survey](#)

[Appendix D: Denver Public Library Staff Survey Response Tables](#)

[Appendix E: Customer Contacts](#)

[Appendix F: DPL Program Presentation to City of Denver](#)

[Appendix G: Professional Quality of Life Scale \(PROQOL\)](#)

[Appendix H: WRAP® Participant Demographics and Workshop Satisfaction](#)

[Appendix I: Brief Resiliency and Coping Self-Efficacy Scales](#)

[Appendix J: Peer Support Specialist Interviews - Protocol and Summary Report](#)



# Appendix A: Script for Key Informant Interviews at Public Libraries

## Interview Protocol

### Interviewees:

- Social Worker and PSS supervisor at DPL
- Social Worker and PSS supervisor at DPL
- Security Manager at DPL
- Supervisor of the Community Technology Center at DPL
- Program Manager—Oak Park
- Program Manager—San Francisco

Introduction. Hello! Thank you for meeting with me today. My name is \_\_\_\_\_, and I am a program evaluator with the University of Colorado. I am contracted as an independent evaluator of the Peer Support Specialist Program at DPL. Part of our evaluation process involves conducting brief interviews with library staff who are in a good position to speak about the program. \_\_\_\_\_ identified you as someone with first-hand knowledge of the program who might be willing to answer a few questions. Would you mind if I recorded our conversation today? Your name won't be used in any of our reports, but we may use your title or position at DPL. The recording is just for accuracy purposes, and we won't share it with anyone outside of our evaluation group. Thank you!

### Questions for all 4 interviewees:

1. Tell me about your roll at DPL, and how long you have been employed in your current position?
2. When did you first become introduced to the PSS program at DPL, and what was your initial impression when you heard about it?
3. How has the PSS program impacted your own work at DPL, specifically? (maybe? Depending on who you are talking to)
4. How has the PSS program impacted the library and community more generally?
5. What do you appreciate most about the program?
6. What are the biggest challenges faced by PSSs in the work they do at DPL?
7. Do you see ways to increase the outreach to include more individuals?
8. In your opinion, how is the PSS program perceived by the community?
9. How could this program as a whole be improved? How could this program be more impactful?
10. If you could have any ONE thing to make the program better, what would it be?
11. Have you witnessed (or been involved with) any memorable or meaningful interactions between library customers and peer support specialists that you would like to share?

### A few additional questions for National Programs:

1. Tell me a little bit about the history of the Program?
2. How is your Peer Support Specialist Program Funded? (Or, how was it funded initially?)
3. How many Peer Support Specialists does your program employ? Are they part or full time? How many hours? Are they located at one central branch? Or multiple branches?
4. How are Peer Support Specialists supervised? Do they receive formal supervision during the week? If so, by whom?
5. What kind of training to PSSs receive prior to working at the library?
6. How do you think the peer program has impacted the capacity of the library staff to do their work?
7. What do think has been the value of having peer support specialists working with customers in the library?

**Additional Questions for social workers:**

1. Do you feel the PSSs employed at DPL received adequate training and were adequately prepared for their work at DPL?
2. What resources or trainings have been most beneficial to the PSSs you supervise for the work they do at DPL? What *additional* resources or training would be most beneficial?
3. Do you feel that the library staff have been generally supportive of the PSSs and the work they are doing at DPL?
4. What have been the biggest challenges in supervising PSSs at DPL?

**Additional Questions for Security Manager:**

1. What is your understanding of the role of a PSS? For example, what are their main objectives?
2. Would you suggest changing or modifying their roles in any way? If so, what would your recommendations be?
3. Has having the PSS program at DPL supported the goals of the Security Department? If so, how?
4. How often do members of the security team refer customers to peer support specialists for assistance?
5. Additional Questions for Supervisor and Program Managers:
6. What is your understanding of the role of a PSS? For example, what are their main objectives?
7. Would you suggest changing or modifying their roles in any way? If so, what would your recommendations be?

**Additional Questions for the Community Technology Center Manager:**

1. Has having the PSS program at DPL supported the goals of the Community Technology Center? If so, how?
2. \_\_\_\_\_ mentioned that a member of your team shadows the peers on Thursdays. Can you tell me more about that?

## Appendix B: Denver Public Library Peer Support Specialist Survey and Response Tables

An online survey, developed using the Qualtrics software platform, was administered to PSSs approximately one year after the launch of the “It Takes a Library” pilot program. PSSs were allowed to complete the survey during their work hours, and the survey took approximately 15 minutes to complete. The survey consisted of quantitative, Likert scale items, as well as open ended questions. Responses were recorded by the software and only members of the evaluation team had access to individual survey responses. *For all Tables, numbers refer to the number of PSSs (out of 4) who endorsed each response option.*

Click this link to preview the Denver Public Library Peer Support Specialist Experiences Survey:

[https://ucdenver.co1.qualtrics.com/jfe/preview/SV\\_dmvaptT2XOpPKmx?Q\\_SurveyVersionID=current&Q\\_CHL=preview](https://ucdenver.co1.qualtrics.com/jfe/preview/SV_dmvaptT2XOpPKmx?Q_SurveyVersionID=current&Q_CHL=preview)

**Table 1. Helpfulness of Peer Support Specialist Training Components**

	Not at all Helpful	A Little Helpful	Moderately Helpful	Very Helpful	Extremely Helpful
Mental Health and Substance Use Recovery	0	0	0	0	4
Supporting and Mentoring Others	0	0	0	0	4
Strength Based Perspective	0	0	0	0	4
Trauma Informed Practices	0	0	0	0	4
Stigma	0	0	0	1	3
Good Communication Skills	0	0	1	0	3
Role of a Peer Support Specialist	0	1	0	0	3
Stages of Recovery	0	0	0	2	2
Stages of Change and Motivational Interviewing	0	0	1	1	2
Group Facilitation	1	0	1	0	2
Self-Care	0	0	0	1	3
Mental Health and Substance Use Conditions	0	0	0	0	4
Ethics and Ethical Responsibilities	0	0	1	0	3
Advocacy	0	0	1	0	3
Working through Conflict	0	0	0	1	3
Differing Values	0	0	0	1	3
Cultural Awareness	0	0	0	2	2
Integrated Health	0	0	1	0	3
Goal Setting	0	0	2	1	1
Problem Solving	0	0	0	2	2
Finding Resources	0	0	1	1	2

Table 2. Peer Support Specialist Knowledge and Competency

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
I know when and how to refer my clients to other services, resources, and/or providers	0	0	0	0	4
I know how to advocate for my clients	0	0	0	1	3
I know how to support my clients with many of the challenges they may be experiencing	0	0	0	1	3
I know how to support my clients manage crises they may be experiencing	0	0	0	2	2
I know how to set good boundaries between myself and my clients	0	0	0	0	4
I feel comfortable supporting people with different beliefs and values	0	0	0	0	4
I feel comfortable supporting people in culturally diverse settings	0	0	0	1	3
I feel comfortable providing support to people around their goals	0	0	0	0	4
I feel comfortable asking for help when I need it	0	0	0	0	4
I know how to practice good self-care	0	0	0	2	2

Table 3. Peer Support Specialist Activities

	Never	Not Very Often	Sometimes	Very Often	All the Time
Support my clients with their self-identified recovery goals	0	1	2	0	1
Coach and mentor my clients with their self-identified goals	0	2	0	1	1
Support my clients with career/education goals	0	3	0	0	1
Support my clients in crisis (e.g. mental health crisis, need for emergency medical care)	0	0	2	1	1
Share or teach wellness tools	0	1	1	0	2
Role model recovery through self-disclosure	0	1	1	1	1
Facilitate support groups	3	1	0	0	0
Instruct psychoeducational support groups	3	1	0	0	0
Advocate for my clients with healthcare providers or other service providers	1	0	0	2	1
Support my clients in navigating complex systems (e.g. healthcare, legal, social services)	0	1	0	0	3
Refer my clients to appropriate services (e.g. substance use treatment, mental health services)	0	0	0	1	3
Assist my clients in obtaining important documents (e.g. ID, SS Card)	1	0	0	1	2
Assist my clients in obtaining benefits (e.g. SNAP, Medicaid, WIC, VA)	1	0	0	2	1
Assist my clients with housing needs	0	1	1	1	1
Assist my clients with immediate physical needs (e.g. food, shelter)	0	0	0	0	4
Assist my clients with transportation needs	0	0	0	2	2
Assist my clients with health literacy	0	1	1	2	0
Provide educational materials and resources to my clients	0	1	1	1	1

**Table 4. Peer Support Specialist Professional Support**

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
My supervisor understands my role	0	0	0	0	4
I feel like my work is valued by my supervisor	0	0	0	0	4
I feel supported by my supervisor	0	0	0	0	4
My supervisor treats me with respect	0	0	0	0	4
My coworkers/team understand my role	0	0	0	1	3
I feel like my work is valued by my coworkers	0	0	0	0	4
I feel supported by my coworkers	0	0	0	0	4
My coworkers treat me with respect	0	0	0	0	4
I have an opportunity to connect with other PSSs where I work or in the community	0	0	0	2	2
I feel like my work is valued by my organization	0	0	0	0	4
I feel supported by my organization	0	0	0	0	4
My organization treats me with respect	0	0	0	0	4
My organization understands the concept of recovery	0	0	0	2	2
Service providers I interact with outside of my place of employment treat me with respect	0	0	1	1	2

**Table 5. Peer Support Specialist Professional Outlook**

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
I can make a living as a PSS	1	1	0	0	2
My work as a PSS is providing me with valuable experience	0	0	0	0	4
My work as a PSS is providing me with valuable training opportunities	0	0	0	1	3
My work as a PSS is helping me gain valuable skills	0	0	0	1	3
My work as a PSS is making me more attractive as a candidate for future employment opportunities	0	0	0	1	3



## Peer Navigator Program at Denver Public Library

**Share your thoughts!** This survey was developed by program evaluators at the University of Colorado in partnership with the Colorado Mental Wellness Network (CMWN). Our goal is to collect information about the Peer Navigator (PN) Program from library staff who have *first-hand knowledge*.

Only members of the evaluation team and CMWN will have access to your responses, and your identity won't be shared in any of our reporting (although we may use quotes from your responses). Your thoughts on the program are valuable and greatly appreciated. **Thank you for participating!**

Please state your position or role at DPL: \_\_\_\_\_

Please state how long you have been employed at DPL: \_\_\_\_\_

Please indicate the extent to which you *Agree* or *Disagree* with each of the following statements using the scale provided below:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
①	②	③	④	⑤

1. Watching peer navigators working with people in the library helps to remind the staff that recovery is possible, even for people going through really hard times.

① ————— ② ————— ③ ————— ④ ————— ⑤

2. Sometimes, peers can be more effective than other professionals in supporting vulnerable customers because they have experienced what people are going through.

① ————— ② ————— ③ ————— ④ ————— ⑤

3. Having peer navigators at DPL has allowed other library staff to focus more time on their own library work.

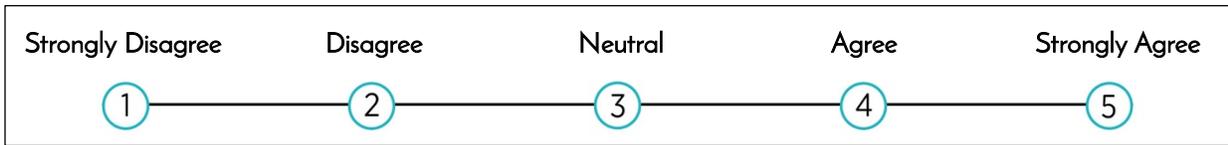
① ————— ② ————— ③ ————— ④ ————— ⑤

4. Being able to refer library customers to peers who are knowledgeable about community resources is helpful.

① ————— ② ————— ③ ————— ④ ————— ⑤

5. The peer navigators at DPL are a valuable addition to the library staff.

① ————— ② ————— ③ ————— ④ ————— ⑤



6. Having peers in the library has allowed customers who were behaving in a disruptive way to spend more time in the library than they would have been able to otherwise.



7. The PN Program should be expanded to other library branches around Denver.



8. The relationships and connections that peers form with library customers help to create a more positive library environment.



9. The peer navigators at DPL are professional.



10. As a result of the PN Program, there have been fewer incidents requiring library security to intervene.



11. The Denver Public Library should hire more peer navigators.



12. The PN Program has changed the dynamics of DPL for the better.



In the space below, please share **any additional thoughts or opinions** on the Peer Navigator Program at the Denver Public Library.

## Appendix D: Denver Public Library Staff Survey Response Tables

A survey was developed to assess the impact of the “It Takes a Library” pilot program on library dynamics and staff. The survey consisted of 12 Likert scale items and one open-ended question (which generated data for the “Illustrative Quotes”). The evaluation team coordinated with a DPL staff member to administer paper and pencil surveys to 34 staff members. Completed surveys were placed in an envelope and a member of the evaluation team collected the surveys, entered data, and synthesized findings. *For all Tables, numbers refer to the number of DPL Staff Members who endorsed each response option. Rows that do not add up to 34 reflect missing data for some survey items.*

### Table 6. Library Dynamics

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Having peers in the library has allowed customers who were behaving in a disruptive way to spend more time in the library than they would have been able to otherwise.	0	3	7	12	12
The relationships and connections that peers form with library customers help to create a more positive library environment.	0	0	0	11	23
As a result of the PSS Program, there have been fewer incidents requiring library security to intervene.	0	4	6	12	11
The PSS Program has changed the dynamics of DPL for the better.	0	0	3	13	18

### Table 7. Staff Capacity and Impact

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Having peer support specialists at DPL has allowed other library staff to focus more time on their own library work.	0	0	1	10	23
Being able to refer library customers to peers who are knowledgeable about community resources is helpful.	0	0	0	7	27
The peer support specialists at DPL are a valuable addition to the library staff.	0	0	2	3	29

### Table 8. Modeling Recovery

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Watching peer support specialists working with people in the library helps to remind the staff that recovery is possible, even for people going through really hard times.	0	1	2	9	22
Sometimes, peers can be more effective than other professionals in supporting vulnerable customers because they have experienced what people are going through.	0	0	2	8	24

### Table 9. Program Expansion

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The PSS Program should be expanded to other library branches around Denver.	0	1	1	10	22
The Denver Public Library should hire more peer support specialists.	0	2	3	9	20

## Appendix E: Customer Contacts

Peer Support Specialists at DPL recorded information about every customer contact on a tracking spreadsheet developed in consultation with the evaluation team. Once a month, the lead social worker sent de-identified tracking data through Google Spreadsheets to the evaluation team. Data were combined across PSSs and months to generate summary statistics provided below. *Percentages do not add up to 100% because PSSs often assisted clients or offered support within multiple domains on any given visit.*

**Table 10: Services and Referrals Provided to DPL Customers**

Services Provided	Number of times service or referral was provided	Percentage of contact during which service or referral was provided
Housing Support	903	38%
Homeless Resources	1507	53%
Mental Health Services	478	17%
Substance Treatment Services	351	12%
Physical Health Services	768	27%
Legal Support	295	10%
State Benefits Support	402	14%
Employment Support	290	10%
SSA	181	6%
Legal Documents Support	365	13%
VI-SPDAT*	45	1%

\*The Vulnerability Index-Service Prioritization and Detections Assistance Tool was administered for some at-risk customers to assess vulnerability for becoming a crime victim

# Peer Navigator Program at Denver Public Library

## Agenda

History

Success

Current Concerns

Solutions

## History

Collaborated with the Colorado Mental Wellness Network and Department of Human Services in 2016 to write for Justice Assistance Grant (JAG) to create the Peer Navigator Program within the Social Work Program at Denver Public Library. Received JAG and project began October 1, 2016; 4 Peer Navigators hired and onboarded January 1, 2017

Added Office Of Behavioral Health grant (written for and awarded to CMWN). This allowed for addition Peer Navigator hours at DPL

Received Telligen Grant (began 7/1/17) this added 20 hour Peer Navigator position at DPL in August 2017

Created collaboration with Metro Denver Homeless Initiative to use existing grant money (Behavioral Health Wellness Program) to place 20 hour Peer Navigator position at DPL starting in August 2017

In April 2018, increased 20 hour positions to 30 hours

NOTE: CMWN employs the peer navigators due to not having the positions available at DPL

## Where we are Today with Grant Funding

Awarded JAG funding continuation for period of October 2017- December 2017 (received funds)

Awarded JAG funding continuation for period of January 2018 - December 2018 (have not received the funds due to Federal Government's concern about "Sanctuary Cities")

OBH grant renewed to CMWN for July 1, 2018 - June 30, 2019

Telligen grant not renewed past June 30, 2018 (we anticipated this as they usually fund one year, take a year off, then fund again).

MDHI did not receive renewal on the BHWP grant after June 30, 2018

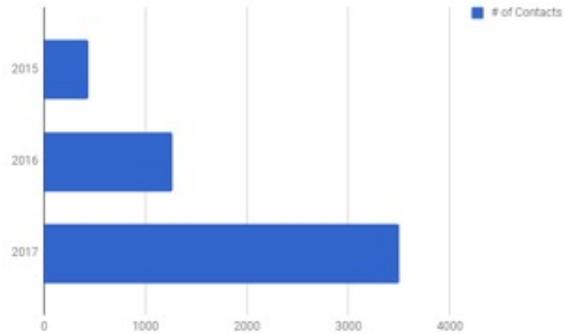
# Metrics and Results of the Peer Navigator Program

706% Increase in customer contacts at DPL between 2015 and 2017

2015: 434

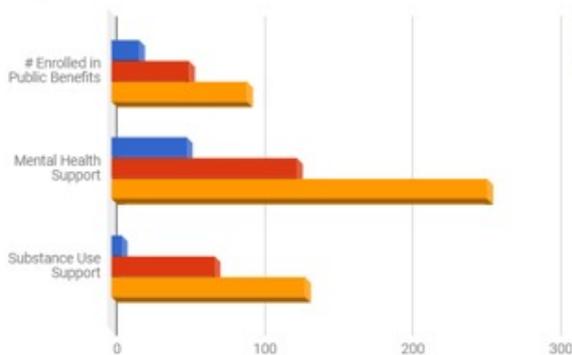
2016: 1265

2017: 3501



## Results, continued

2015, 2016 and 2017



<b>2015:</b>	
Public Benefits	19
Mental Health Support	51
Substance Use Support	7
<b>2016:</b>	
Public Benefits	53
Mental Health Support	126
Substance Use Support	70
<b>2017:</b>	
Public Benefits	92
Mental Health Support	254
Substance Use Support	131

## Quotes from DPL Safety Survey by DPL Staff



"I love working here because I get to be the person that I needed."  
~Cuica Montoya, Peer Navigator

"The [peer] navigators and social workers, along with security staff have really made a huge difference in feeling safe in the library. Teamwork continues to grow throughout the library...and as we work together, we become better helpers for all of our customers."

"The Social Work/Peer Navigator contribution has been important. An opportunity to provide help and support to those obviously seeking it. This has been invaluable in working with and developing a relationship with any number of folks who come through our branch."

## Quote from a DPL Security Staff

"I have worked for the Security Department of DPL at the Central Library for 23 years. For many of those years, even though there were many customers who were homeless, suffered from addiction, depression or had other needs, we were enforcers of policy and procedure and, even if we wanted to help, we weren't trained to assist them and didn't know how. All we (SEC) could do for many years was call "someone" (usually DPD), or simply do nothing except enforce policy and hope that the customer could find the services they needed.

When DPL added full time social workers to our staff, we (SEC) noticed that people were actually getting help. They are getting redirected to the services they need. Two social workers, however, cannot be everywhere.

The peer navigators help with this. They are able to assist our customers. They have life experiences that we (SEC) do not have. While we (SEC) can empathize with a customer's struggles, our peer navigators truly *understand*. They lead by example. They show everyone how life really can "work out" for a person who is struggling with addiction, or depression, or homelessness, or (the list goes on and on), but that people can overcome their struggles if they receive the help they need.

Sometimes our customers just need someone to listen to them - to show that someone really does care. I often see the peer navigators do just that. They care. They help. They are needed." ~ Polly Proctor

## One More Quote from a DPL Security Staff

"I have been an employee with Denver Public Library- Central Branch for approximately 9 months, and work in the security department here. Day to day the security department makes large amounts of customer contacts for various things, mainly pertaining to individuals breaking company policies. I would say that most of the contacts we make involve individuals that are intoxicated or have mental health issues. When we make such contacts it is incredibly helpful to have peer navigators with us during these contacts to have them speak with the individual and hopefully be able to help connect them with resources we otherwise would not be able to do. Countless times I have seen the peer navigators successfully connect individuals with resources I didn't even know existed. They are hardworking, selfless people that do a very difficult job, and have a very high success rate. I personally believe that the Community Resource Specialists and peer navigators are pertinent to the functioning of the Denver Public Library, they are irreplaceable and an amazing asset to have." ~ Ellen Marsh

### The Peer Navigators Have Allowed the Social Workers to:

- Develop More Training for Staff

- Mental Health First Aid
- Homelessness 101
- Trauma Informed Systems of Care
- Finding Resiliency: An Approach to Self Care
- Intersections of Mental Health, Substance Use, and Trauma
- Narcan Use



- Widen Net of Services

- Creation of two new SW positions:
  - STIR
  - Families and Youth

- Develop Programming for Customers

- Hard Times Writing Program
- Meditation
- Coffee Connections
- *Resulting in Healthy Relationships Between Staff and Customers*

- Increase Partnerships with Agencies

- Be a Part of the Solution

- Citywide Collective Impact on Substance Use



# A Model to Follow

Present the Peer Navigator Model Nationally as an Evidenced Based Practice

- Public Library Association Conference March 2018: with SFPL and DCPL. DPL modeled peer program after San Francisco's program, DC modeled their peer program after San Francisco and Denver. Other library systems considering the model.
- Innovation for Local Government Conference April 2018: with e-civis. Several in attendance are considering creating a peer program in their library, parks department, etc.
- International Capital Market Association Conference September 2018: with e-civis

Role Model Success and Recovery City Wide

- Consideration for peer program within recovery courts
- Consideration for peer program within Collective Impact to address Substance Use

# Current Concerns

The collaboration with the Colorado Mental Wellness Network has allowed the opportunity to create a successful nationally known peer navigator model at DPL. Changes in leadership personnel at the end of 2017 have led to issues within this collaboration. These include:

- Lack of communication about budget planning
- Difficulty in coordination on grant budget management jeopardizing ability to fulfill obligations to funders and solicit future funding

## Solutions

Create four Outreach Case Coordinator Positions within DPL as of July 1, 2018, so we can maintain these vital positions.

Use vacancy savings in the DPL personnel budget to fund these positions through 2018

Make these positions permanent positions as of 2019 and add 2 more (=6)

Additional Needs: Money for supplies (used as engagement tools) (RTD tickets; snacks; chapstick; hygiene products, etc.) = \$14,620 for 6 months

# Appendix G: Professional Quality of Life Scale (PROQOL)

## PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

### COMPASSION SATISFACTION AND COMPASSION FATIGUE

#### (PROQOL) VERSION 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

**1=Never**

**2=Rarely**

**3=Sometimes**

**4=Often**

**5=Very Often**

- \_\_\_\_\_ 1. I am happy.
- \_\_\_\_\_ 2. I am preoccupied with more than one person I [help].
- \_\_\_\_\_ 3. I get satisfaction from being able to [help] people.
- \_\_\_\_\_ 4. I feel connected to others.
- \_\_\_\_\_ 5. I jump or am startled by unexpected sounds.
- \_\_\_\_\_ 6. I feel invigorated after working with those I [help].
- \_\_\_\_\_ 7. I find it difficult to separate my personal life from my life as a [helper].
- \_\_\_\_\_ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
- \_\_\_\_\_ 9. I think that I might have been affected by the traumatic stress of those I [help].
- \_\_\_\_\_ 10. I feel trapped by my job as a [helper].
- \_\_\_\_\_ 11. Because of my [helping], I have felt "on edge" about various things.
- \_\_\_\_\_ 12. I like my work as a [helper].
- \_\_\_\_\_ 13. I feel depressed because of the traumatic experiences of the people I [help].
- \_\_\_\_\_ 14. I feel as though I am experiencing the trauma of someone I have [helped].
- \_\_\_\_\_ 15. I have beliefs that sustain me.
- \_\_\_\_\_ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
- \_\_\_\_\_ 17. I am the person I always wanted to be.
- \_\_\_\_\_ 18. My work makes me feel satisfied.
- \_\_\_\_\_ 19. I feel worn out because of my work as a [helper].
- \_\_\_\_\_ 20. I have happy thoughts and feelings about those I [help] and how I could help them.
- \_\_\_\_\_ 21. I feel overwhelmed because my case [work] load seems endless.
- \_\_\_\_\_ 22. I believe I can make a difference through my work.
- \_\_\_\_\_ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
- \_\_\_\_\_ 24. I am proud of what I can do to [help].
- \_\_\_\_\_ 25. As a result of my [helping], I have intrusive, frightening thoughts.
- \_\_\_\_\_ 26. I feel "bogged down" by the system.
- \_\_\_\_\_ 27. I have thoughts that I am a "success" as a [helper].
- \_\_\_\_\_ 28. I can't recall important parts of my work with trauma victims.
- \_\_\_\_\_ 29. I am a very caring person.
- \_\_\_\_\_ 30. I am happy that I chose to do this work.

## YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

---

### Compassion Satisfaction \_\_\_\_\_

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

---

### Burnout \_\_\_\_\_

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

---

### Secondary Traumatic Stress \_\_\_\_\_

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

## WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section**, total the questions listed on the left and then find your score in the table on the right of the section.

### Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added them up you can find your score on the table to the right.

3. \_\_\_\_\_  
 6. \_\_\_\_\_  
 12. \_\_\_\_\_  
 16. \_\_\_\_\_  
 18. \_\_\_\_\_  
 20. \_\_\_\_\_  
 22. \_\_\_\_\_  
 24. \_\_\_\_\_  
 27. \_\_\_\_\_  
 30. \_\_\_\_\_

**Total:** \_\_\_\_\_

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

### Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about

- \*1. \_\_\_\_\_ = \_\_\_\_\_  
 \*4. \_\_\_\_\_ = \_\_\_\_\_  
 8. \_\_\_\_\_  
 10. \_\_\_\_\_  
 \*15. \_\_\_\_\_ = \_\_\_\_\_  
 \*17. \_\_\_\_\_ = \_\_\_\_\_  
 19. \_\_\_\_\_  
 21. \_\_\_\_\_  
 26. \_\_\_\_\_  
 \*29. \_\_\_\_\_ = \_\_\_\_\_

**Total:** \_\_\_\_\_

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

You Wrote	Change to	
	5	the effects of helping when you are <i>not</i> happy so you reverse the score
2	4	
3	3	
4	2	
5	1	

### Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added them up you can find your score on the table to the right.

2. \_\_\_\_\_  
 5. \_\_\_\_\_  
 7. \_\_\_\_\_  
 9. \_\_\_\_\_  
 11. \_\_\_\_\_  
 13. \_\_\_\_\_  
 14. \_\_\_\_\_  
 23. \_\_\_\_\_  
 25. \_\_\_\_\_  
 28. \_\_\_\_\_

**Total:** \_\_\_\_\_

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

## Appendix H: WRAP® Participant Demographics and Workshop Satisfaction

Participants of WRAP workshops from the target population completed a brief demographic survey at the beginning of each workshop. At the end of an overview session or a workshop, both providers and individuals from the target population completed a second brief survey to assess their satisfaction with the overview session or workshop. Surveys were administered by the WRAP facilitators and transferred to the evaluation team for data entry and synthesis.

**Table 11. WRAP® Participant Demographics**

<b>Age:</b>	
24-30	10%
31-45	35%
46-64	52%
65-74	3%
<b>Ethnicity:</b>	
Hispanic	10%
Non-Hispanic	80%
Prefer not to answer	10%
<b>Race:</b>	
American Indian/Alaska Native	3%
Black/African American	7%
White/Caucasian	69%
Multi-Racial	7%
Other	7%
Prefer not to answer	7%
<b>Gender:</b>	
Male	24%
Female	66%
Other or Prefer not to answer	10%
<b>Income:</b>	
Less than \$10,999	33%
\$10,000 - \$19,999	30%
\$20,000 - \$29,999	7%
\$30,000 - \$39,999	11%
\$40,000 - \$49,999	7%
Over \$50,000	7%
Prefer not to answer	4%

<b>Insurance:</b>	
Medicaid	76%
Medicare	17%
Private	10%
Veteran	7%
None	3%
<b>Employment:</b>	
Employed Part Time	17%
Employed Full Time	28%
Not Employed and No Benefits	17%
SSI	17%
SSDI	21%
Veteran's Benefits	3%
Prefer not to answer	3%
<b>Relationship to Mental Health:</b>	
Personal experience with a mental health condition	35%
Personal experience with a substance use condition	14%
Both a mental health and substance use condition	38%
No personal experience with either	3%
Prefer not to answer	7%
<b>Experience of Victimization:</b>	
Domestic Violence	48%
Sexual Assault	41%
Stalking	28%
<b>Currently experiencing homelessness or risk of homelessness</b>	<b>21%</b>
<b>Currently involved in the criminal justice system</b>	<b>24%</b>

**N = 29**

**Table 12. WRAP® Participant Workshop Satisfaction**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The facilitator(s) was/were knowledgeable about the topics discussed.	2%	0	2%	29%	67%
The ideas were clearly presented.	1%	1%	4%	34%	60%
The facilitator(s) was/were engaging.	1%	0%	5%	33%	61%
This workshop provided me with practical tools I can use.	1%	1%	5%	38%	55%
In general I am satisfied with this workshop.	1%	1%	6%	35%	57%
I would recommend this workshop to others.*	0	0	0	22%	78%

**N = 144**

*\* This item was added later in the year, so only 18 individuals responded to this item*

## RESILIENCY AND SELF-EFFICACY

CMWN invites you to participate in this brief survey of the strategies and techniques you use to maintain your wellness. The Network seeks honest feedback from all WRAP® Workshop participants. Responses are confidential and anonymous. Information collected from this survey will be used for the purpose of improving our services and workshops and helps to ensure funding continues for our programs. Thank you for participating!

### Resiliency

Please respond to each item by marking one box per row.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I tend to bounce back quickly after hard times.	<input type="checkbox"/>				
2. I have a hard time making it through stressful events.	<input type="checkbox"/>				
3. It does not take me long to recover from a stressful event.	<input type="checkbox"/>				
4. It is hard for me to snap back when something bad happens.	<input type="checkbox"/>				
5. I usually come through difficult times with little trouble.	<input type="checkbox"/>				
6. I tend to take a long time to get over set-backs in my life.	<input type="checkbox"/>				

(Please continue on the next page.)

Chesney MA, Neilands TB, Chambers DB, Taylor JM, Folkman S. (2006). A validity and reliability study of the coping self-efficacy scale. *British Journal of Health Psychology* 11(3): 421-37.

Smith, BW, Dalen, J, Wiggins, K, Tooley, E, Christopher, P, & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. *International Journal of Behavioral Medicine* 15(3), 194-200.

## Coping Self-Efficacy

For each of the following items, write a number from 0 - 10, using the scale below.

Cannot do at all		Moderately certain can do						Certain can do		
0	1	2	3	4	5	6	7	8	9	10

When things aren't going well for you, or when you're having problems, how confident are you that you can do the following:

1. Keep from getting down in the dumps. \_\_\_\_\_
2. Talk positively to yourself. \_\_\_\_\_
3. Sort out what can be changed, and what can not be changed. \_\_\_\_\_
4. Get emotional support from friends and family. \_\_\_\_\_
5. Find solutions to your most difficult problems. \_\_\_\_\_
6. Break an upsetting problem down into smaller parts. \_\_\_\_\_
7. Leave options open when things get stressful. \_\_\_\_\_
8. Make a plan of action and follow it when confronted with a problem. \_\_\_\_\_
9. Develop new hobbies or recreations. \_\_\_\_\_
10. Take your mind off unpleasant thoughts. \_\_\_\_\_
11. Look for something good in a negative situation. \_\_\_\_\_
12. Keep from feeling sad. \_\_\_\_\_
13. See things from the other person's point of view during an argument. \_\_\_\_\_
14. Try other solutions to your problems if your first solutions don't work. \_\_\_\_\_
15. Stop yourself from being upset by unpleasant thoughts. \_\_\_\_\_
16. Make new friends. \_\_\_\_\_
17. Get friends to help you with the things you need. \_\_\_\_\_
18. Do something positive for yourself when you are feeling discouraged. \_\_\_\_\_
19. Make unpleasant thoughts go away. \_\_\_\_\_
20. Think about one part of the problem at a time. \_\_\_\_\_
21. Visualize a pleasant activity or place. \_\_\_\_\_
22. Keep yourself from feeling lonely. \_\_\_\_\_
23. Pray or meditate. \_\_\_\_\_
24. Get emotional support from community organizations or resources. \_\_\_\_\_
25. Stand your ground and fight for what you want. \_\_\_\_\_
26. Resist the impulse to act hastily when under pressure. \_\_\_\_\_

# Process Evaluation of the Role of Peers Working in a Non-Traditional Behavioral Health Setting

By: Courtney Burgad, Amanda Pavlak, Hannah Hoekstra



BE WELL. HAVE HOPE. *pass it on.*



The purpose of this process evaluation is to explore the implementation of peer navigators at the Denver Public Library (DPL) to determine the obstacles and challenges peers are experiencing, how peer navigators are delivering services and support to individuals in a nontraditional setting, and what additional supports would be useful to perform their roles more effectively.

**Colorado Mental Wellness Network**

## Literature Review

Colorado Mental Wellness Network (CMWN) started offering peer navigator training in 2012. CMWN focuses on evidence-based recovery education to people who do not find treatment to be enough for their recovery process. CMWN is dedicated to advocating for and providing opportunities for peer navigators to improve the quality of their life, give back to the community by being in meaningful peer navigator roles, and to help change the perception of mental health. The CMWN is the only peer-operated mental health organization that offers an 80-hour curriculum for peer navigators to become certified with support from the International Association of Peer Supporters.

Peer navigators are defined as individuals who have faced and overcome adversity, and are maintaining stability, housing, sobriety, and even thriving in their personal growth and well-being (Davidson, Chinman, Sells, & Rowe, 2006; Chant, 2017). The recovery approach to a mental disorder or substance dependence identifies and reinforces a person's potential for recovery and is an approach that fits with peer navigators' role when working with individuals seeking services (SAMHSA, 2017).

Research has demonstrated that peer support is essential to a recovery-oriented and consumer-driven system, and that it influences the entire mental health system to be more recovery-orientated (Hermann & Palmer, 2012). Research has shown that peer navigators in nontraditional settings should work together with other mental health professionals to implement care for clients.

Peer navigators

at the

*Denver Public Library*

Mental health services are working to meet the needs of their populations, but many programs report that they are still in the planning stages of including peer navigators (Hebert et al., 2008). There is still evidence needed to promote the practice of peer navigators to become evidence-based including models, manuals, training curriculum, and fidelity measures to better understand what peer navigators are doing with their life experiences, under what circumstance, and to what effects (Davidson et al., 2006). The relationship between peer navigators and mental health professionals is something that society needs to be thoughtful about and aware of.

There are many benefits of using peer navigators in a workplace to improve the quality of life for clients and improve engagement and satisfaction with services. Peer navigators can help individuals improve on their overall health including chronic illness and reduces the cost of services. With suitable support, training and supervision, people with lived experiences of mental illness can provide meaningful psychosocial, emotional and practical support to other consumers (Lawn, Smith, & Hunter, 2008).

## Methodology

This process evaluation used a qualitative method with individual semi-structured interviews to explore how peer navigators perceive their roles and obstacles, how peer navigators support customers who are not engaging in traditional settings, and how agencies could better support peer navigators in performing their roles. Interviews were scheduled with four peer navigators at the DPL and were expected to last approximately 45-60 minutes. Two researchers conducted each interview, which was guided by the interview schedule. One researcher lead the interview while the other researcher took notes to ensure the credibility of the interview. The interviews were recorded by an audiotape and then transcribed after the interview for coding. The sample consisted of four adult peer navigators at the DPL who are employed part-time by the CMWN and have been working in their role for one year or less.

## Research Questions and Qualitative Results

1

How do peer navigators in nontraditional settings report engaging with and supporting individuals who are not accessing other traditional support?

“Outreach is basically looking for people who are in trouble or someone who looks like they need something.”

Findings	Interpretations
-Drop-In Hours	-3 hours per day on weekdays for customers to engage with peer navigators
-Day to day varies	-Never knowing what to expect, day to day task change and vary
-Resources	-Connecting customers to food stamps, ID's, and housing, etc.
-Safety	-By providing a safe space and allowing the customers voice and concerns to be heard
-Outreach	-Walking around the DPL in search of customers who are in need, ensuring rules of the DPL are followed

2

What obstacles and challenges do peer navigators encounter in a nontraditional setting? What obstacles do they encounter when interfacing with traditional healthcare and mental health organizations?

“The job can be emotionally draining by wanting to fix everything, know everything, having to see people suffer, and knowing there is nothing I can do for them.”

Findings	Interpretations
-Resources	-Not having appropriate resources and not knowing/learning all the resources
-Emotionally Draining	-Frustrated because wanting to fix and know everything
-Beginning Stages	-Feelings of being in survival mode, knowing where to connect customers, wanting to fix customers problems
-Untreated symptoms such as psychosis or schizophrenia	- When customers are experiencing psychosis, being unsure how to treat them or help and feel it is more of a social work role than a peer navigator role
-Interacting with traditional settings	-Unsure if the professionals in the community completely understand their role as a peer navigator

Research Questions and Qualitative Results

3

What additional supports do peer navigators identify as potentially useful to engage in their roles more effectively?

Findings

Interpretations

-Self-care

-Sleep, rest, food, hanging with friends, and contacting family

-Safe Environment

-DPL is a safe setting for customers and peer navigators due to security

-CAC Training

-Certified Addiction Counselor classes

-Outside Resources

-Therapy, medication, 12 step fellowship programs

-Library Staff

-Staff understanding and being knowledgeable of the peer navigator roles

“I just need to add things, what am I doing here I need to add things sort of outside, and the CAC training would be one of them.”

4

How do peer navigators describe the preparation, training, and supervision received for their role and what additional preparation, training, or supervision would be beneficial?

Findings

Interpretations

-Comfortable

-Feeling comfortable with their supervisor and peers for support

-Continued Training

-Peers enjoy the training they are receiving, but hope on-going training continues

-Supervision

-Done weekly with the two Social Workers for one hour once a week

-Training provided by the CMWN

-WRAP program provided by the CMWN prior to engaging in their role as a peer navigator

-Informal Check-In's

-Supervisors asking "how the day went" and giving the peer navigators an option to discuss concerns if they are present

“I feel like it just expanded my entire awareness for my own journey of recovery.”



## Discussion

### Study Limitations

The limitations of this study includes a lack of prior research on the topic, self-reported data, time constraints, and small sample sizes. Overall there was a lack of previous research on peer navigators in nontraditional settings to help guide the research completed. Instead, the research was mainly based on traditional settings. Self-reported data was a limitation due to the lack of depth in results. The respondents may have felt vulnerable to reveal vulnerable details around the research questions. Another limitation was the inability to member check with peers after the interviews due to the lack of time allotted for the research project. A time constraint also involved the length of the individual interviews, since all interviews did not fulfill the 60-minute timeframe. Lastly, the research project started with five navigators, but when the interviews were conducted, there were only four peer navigators to interview. This then posed an even smaller sample size than expected.

### Study Strengths

Strengths of the study include the agency's willingness to allow researchers to engage in evaluation of the peer navigator program which created access to participants and a confidential space for interviews to be conducted. The questions asked by the researchers went through several revisions and received comprehensive input and feedback from all group members and CMWN to ensure the questions were adequately reflecting needed information. The information obtained from the interviews will allow for adjustments and implementation for the peer navigator program and services as required. Three researchers completed the inter-coding process to ensure the credibility of the study. After the interviews took place and came together to discuss common themes that were found in the coding process.

### Conclusion and Recommendations

The first recommendation is connected to continued training for peer navigators. As represented in the findings, peer navigators identified the importance of training. Providing ongoing training for all peer navigators is essential for the peer navigators to be successful and confident in their role. The second recommendation is for the CMWN to continue to conduct further research to better understand the consumers' experiences when engaging with peer navigators. Since the interviews were limited in time and sample size, it does not allow for an overgeneralization of the findings from the research. Future researchers should interview not only the peer navigators, but the professionals of the DPL and the customers to observe support received, gaps in their system, or areas of concern related to the program to gain a better perspective around peer navigators. The study also suggests that supervisors need to be mindful of peer navigators during the first 3-4 months of employment due to this being a challenging time frame. Overall, comparing the published research with the feedback received from the peer navigators shows that the CMWN appears to have grasped the gaps and needs that have created limitations in the effective use of peers in other settings, and taken efforts to fill those gaps as they implemented a new peer-delivered program.

Thank you Colorado Mental Wellness Network for working with us!



Process Evaluation of the Role of Peers Working  
in a Non-Traditional Behavioral Health Setting  
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## Introduction

A study conducted by the U.S. Substance Abuse and Mental Health Services Administration 2017, reports that groups, organizations, and programs run by and for people with mental illness are outnumbering traditional, professional mental health organizations by a two to one ratio. Colorado Mental Wellness Network (CMWN) is a peer-run agency that contributes to this new phenomenon by providing employment for five peer support specialists (PSS's) in a non-traditional setting at the Denver Public Library (DPL). CMWN is working to bring greater credibility and legitimacy to how PSS's are viewed by professionals and other mental health agencies in Colorado. They are working to find innovative ways for individuals facing homelessness, substance abuse, mental illness, and traumatic experiences in traditional health and social services settings. The question of whether PSS's are adequately and efficiently delivering interventions, what barriers they are faced with, and how they perceive their roles are topics that require ongoing research (Davidson, et al., 2005). Most research has examined the roles of peers and effectiveness of PSS's services in traditional behavioral health settings, and much less research exists exploring how PSS's might effectively navigate non-traditional settings. Peer outreach in nontraditional settings is a relatively new category of peer support, with research lagging behind innovations in practice.

PSS's are defined as individuals who have faced and overcome adversity, and are maintaining stability, housing, sobriety, and even thriving in their personal growth and well-being (Davidson, Chinman, Sells, & Rowe, 2006; Chant, 2017). PSS's use their success and hardships to mentor and inspire others facing similar situations through a variety of roles. These roles include case management, outreach, wellness coaching, and providing education (Davidson et al., 2006; Mental Health America, 2017). Peer services can be found in both traditional

settings, such as prisons, hospitals, drop-in centers, and homeless shelters, and in nontraditional settings, such as libraries, gyms, and street settings. Across roles and settings, the work of PSS's can also be termed as peer support specialists, peer outreach, peer navigators, recovery coaches, family system navigators, and family advocates (Kearney-Smith & Calabrese, 2014).

PSS services in mental health and substance abuse traditional settings is gaining more attention due to them having impacts on decreasing hospitalizations, increasing employability, and enhancing the well-being and self-esteem of the individuals facing mental illness, addiction, and homelessness. Research supports that people with mental illness in the hospital setting receiving PSS's have significantly lower hospitalizations and fewer inpatient stays (Sledge et al., 2011). A study that compared a year-long PSS's program versus a regular treatment setting reported individuals [in](#) a non-traditional setting receiving PSS's as having improved self-perceptions of mental health, physical health, recovery, and quality of life (Corrigan et al., 2017).

The topic of PSS's may be gaining more attention, but not without substantial obstacles. PSS's have been providing services in Colorado since 1986, and in 2014, five conventions were held around the state to advance and advocate for the profession of PSS's (Kearney-Smith & Calabrese, 2014). Issues addressed were credentialing for PSS's, stigma within community mental health centers related to PSS's, and how to appropriately provide support and supervision to PSS's (Kearney-Smith & Calabrese, 2014). Stereotypes and stigma are factors linked to PSS's that have been identified as a major obstacle for integrating PSS more fully into traditional settings.

This history of the CMWN started in 2012, when they began offering PSS training (Kearney-Smith & Calabrese, 2014). CMWN focuses on evidence-based recovery education to people who do not find treatment to be enough for their recovery process (Kearney-Smith &

Calabrese, 2014). The CMWN is dedicated to advocating for and providing opportunities for PSS's to improve the quality of their life, give back to the community by being in meaningful PSS roles, and to help change the perception of mental health. CMWN changes the perception through advocacy and leadership by speaking up and being involved during legislative sessions, through media, and to family and friends (Colorado Mental Wellness Network, 2017). The CMWN is the only peer-operated mental health organization that offers an 80-hour curriculum for PSS's to become certified with support from the International Association of Peer Supporters (Colorado Mental Wellness Network, 2017). The minimum requirements needed to become a PSS is a high school diploma or GED, sustaining recovery for a minimum of one year, but longer is preferred, commitment to attend all training days, internet access, and a desire to assist others throughout their recovery (Colorado Mental Wellness Network, 2017).

In 2016, the CMWN was awarded a contract with the state of Colorado to implement PSS's at the DPL to increase awareness of services offered, decrease stigma around recovery, and encourage replication of the peer model throughout the state of Colorado. The contract and grant are intended to help serve the clientele at the DPL through PSS's. The clientele often consists of individuals facing homelessness, dealing with mental health, and substance abuse. The Office of Behavioral Health Recovery Services Grant (OBH, 2017) has five goals, objectives, and measures in place to better serve these individuals through the PSS's. The goals and objectives require quarterly reports and updates completed by the CMWN to assess the PSS's model.

Goal one of the contract relates to increasing individuals' ability to access services by expediting and improving transitions between agencies and increasing awareness of recovery support services. The objectives discuss maintaining the clients they have and finding ways to

reach their services to clients who affiliate with Medicaid, SNAP, old age pension, aid to needy disabled, and veterans. CMWN wants to provide transportation to individuals seeking services and create a website identifying all recovery support services available in Colorado. The overall goal is to increase utilization of the PSS's, but it should be noted, that the services offered by PSS's stationed at the DPL are not advertised to the broader community. As of now, the PSS's are used as a harm reduction approach. The PSS's are needed at the DPL due to the population that is utilizing the library. A great deal of the individuals accessing the library services are homeless, and there has been an increase in the number of drug-related overdoses in the library setting (CMWN, 2017). The PSS's are on site and available to the individuals in the setting when needed, throughout crisis situations, to help intervene when police are involved or called to the library, or if the individual is needing help finding appropriate community services. The DPL does not want the setting to become overcrowded with this high need population.

Goal two is to reduce the target population's interactions with law enforcement and help minimize the chances of becoming a crime victim. The objectives are to reduce incident reports filed on the target population, and track referrals from the Department of Public Safety's Community Corrections Division to promote successful re-entry of recently incarcerated victims. The goals and objectives are measured by collecting incident reports, reviewing the log of Denver police calls and arrests, and by assigning codes to individuals to determine the outcomes of interventions provided.

Goal three refers to using an evidenced-based approach to enhance the effectiveness of Denver's system of care to decrease criminal justice involvement among the individuals with high behavioral health needs. The objectives are to provide education to professionals on the use of Wellness Recovery Action Plans (WRAP) and similar recovery tools. A significant aspect of

the CMWN's work is training PSS's to use WRAP, which is a personalized wellness and recovery plan rooted in the principles of self-determination. WRAP is designed to help with mental health conditions, substance misuse, addiction, trauma, relationships, job stress, education, employment, social isolation, medication side effects, managing cancer treatment, and coping with significant life changes and stressors (Colorado Mental Wellness Network, 2017). CMWN will provide the materials and training for at least 25 at-risk community members.

The fourth goal supports having more training opportunities for PSS's. The existing services can enhance and expand services in Colorado. The objectives are to provide no-cost training for PSS's, so they can meet criteria for becoming certified and gain employment. The goals are measured by tracking individuals completing the certificate program and by tracking interactions with individuals receiving services.

Goal five of the contract is to assess the replicability of the model, the impact on individuals and the community, and the ability of the program to achieve its goals and objectives. The CMWN wants to show the community that the DPL PSS's have a positive impact and the training they are provided can lead to peer satisfaction and career development. The CMWN also wants to demonstrate that the PSS's have a positive impact and is an attempt to replicate the model they created across the state.

The purpose of this process evaluation is to explore the implementation of PSS's at the DPL to determine the obstacles and challenges peers are experiencing, how PSS's are delivering services and support to individuals in a nontraditional setting, and what additional supports would be useful to perform their roles more effectively. A process evaluation will ensure the PSS's program is delivering services according to the design and contract. If standards are not being met by the PSS's or the CMWN, the findings may inform how to improve the program,

which may ultimately save time and funding. The evaluation can pinpoint strengths and weaknesses within the program design allowing for future program improvements. CMWN and the OBH will be provided with firsthand feedback from the voices of peers themselves. The information received from the PSS's will be beneficial for the CMWN to improve on the current goals and how to better support their PSS's at the DPL.

## **Literature Review**

### **Historical Context**

The recovery approach to a mental disorder or substance dependence identifies and reinforces a person's potential for recovery and is an approach that fits with the PSS's role when working with individuals seeking services (SAMHSA, 2017). The recovery process does not focus on a person's symptoms; instead it concentrates on the person's well-being. Recovery is believed to be achievable and that it is a process rather than a quick solution (Stickley, 2008). The process anticipates and requires commitment from people with mental illness, their families, mental health professionals, public health teams, social services and the community (Stickley, 2008). PSS are unique to the recovery model process because of their lived experience: such persons have expertise that professional training cannot replicate. Substance Abuse and Mental Health Services Administration (SAMHSA, 2017), has depicted four major dimensions that support life in recovery: health, home, purpose, and community. Health professionals offer support both physically and mentally to promote a healthy well-being. Helping a person with a mental disorder creates a positive outlook on life. Having these organizational systems work together, the process hopes to embrace new and innovative ways of working (SAMHSA, 2017). PSS's can share their experience by providing hope to people in recovery and promote a purpose of belonging to the community.

The recovery approach encourages people with a mental health issue to move forward and set new goals. It supports the perspective of empowering them to evoke a change and develop relationships that give their lives a new meaning (SAMHSA, 2017). The PSS' role may include assisting their peers in setting their goals for recovery, supporting them in their treatment, and modeling effective coping techniques and self-help strategies based on the specialist's own recovery experience. The model portrays that, people with a mental disorder may not have full control over their symptoms, but they can have control over their lives (Stickley, 2008). The recovery approach can be a journey of self-discovery and personal growth; experiences of mental illness can provide opportunities for change, reflection, and discovery of new values, skills, and interests (Stickley, 2008).

The history of PSS's began in the late 18th century when the governor of France, Jean Baptiste Pussin, identified the value of employing recovered patients as hospital staff. Bicêtre Hospital is the first documented psychiatric hospital to begin working with PSS (Davidson, Bellamy, Guy, & Miller, 2012). The trial revealed that hiring former patients marked a shift in the philosophy of mental health care that brought in the "moral treatment" era (Davidson et al., 2012). The ethos was rapidly and widely adopted by the community of mental health consumers. PSS's were not studied again until 1965 with the research of Carkhoff & Truax who were trained counselors with mental health skills. Their goal was to achieve success in helping mentally ill patients in hospital settings (Enright & Parsons, 1976). Professionals such as, Carkhoff & Truax were among the first to advocate for the alliance of PSS's into primary care settings (Carkhoff & Truax, 1965).

In 1967, a researcher, Emory Cowen, proposed a model of community mental health care that required the employment of nonprofessional peers in the development, implementation, and

evaluation of community interventions (Cowen, Gardner, & Zax, 1967). Cowen created this model to emphasize primary care, while matching the needs of the population, and employing "indigenous nonprofessionals," or PSS (Newbrough, 1969). This model helped the philosophy rapidly and widely become adopted by the community of mental health consumers around the world. In the 1970s, significant numbers of state hospitals across the United States were shutting down, releasing patients with severe mental illnesses into the community with inadequate transitional support (Ostrow & Adams, 2012). The release of these patients encouraged them to start speaking out about the mistreatment and denial of civil liberties while under the care of state mental hospitals. Once released, former patients sought relief through self-governing PSS and mutual support groups, which helped empower individuals as well as the community (Ostrow & Adams, 2012).

The PSS's community changed course in the 1980s as it reached out to governmental and professional organizations creating a social movement. This period of re-engagement led to improved mental health care practices, increased funding for technical assistance and training programs, and a subsequent boom in peer support services (Ostrow & Adams, 2012). PSS in the mental health field were among the first to be certified and to qualify for state and Medicaid reimbursement (NFC, 2003). However, Medicaid made some PSS's resistant to facets of Medicaid participation. PSS did not want to lose the value of their role and mission in promoting recovery under a non-medical model by complying with medical necessity criteria (Adler, Bergeson, Brown, & Fox, 2010). PSS's wanted to be recognized as experts in their own right ("expert by experience") operating from a unique set of values and as an essential part of the mental health care system.

During the peer community's social movement in the 1980's, Colorado started its own program of PSS. In 1896, Colorado Division of Mental Health, now referred to as the OBH, started a program in Denver that trained and employed individuals with chronic mental illness (Kearney-Smith & Calabrese, 2014). The goal of this program was to provide case management services to others receiving mental health services at four community mental health centers in Denver (Kearney-Smith & Calabrese, 2014). The participants were called Case Manager Aides (CMAs), and the program was a success: 15 of the original 25 trainees are still employed as Case Manager Aides (Kearney-Smith & Calabrese, 2014). The program's success inspired Nate Rockitter, who created his PSS training program in the Denver area in 1993. Rockitter trained people who were diagnosed with mental health disorders to help them transition into a PSS's role, with a focus on skill building, relationship building and the group process (Kearney-Smith & Calabrese, 2014). Rockitter's plan is still used today. Specific duties and job titles have been altered to fit each program, but the core training provided for PSS's remains the same, by working with those who have faced similar issues and can use their shared experiences to offer a unique service to others (Kearney-Smith & Calabrese, 2014). Throughout history PSS have expanded their services and roles are developing, but ongoing research is needed.

### **Review of Research Evidence**

The evaluation team conducted a literature search through PsycARTICLES, PsycINFO, Social Work Abstracts, PubMed, Social Work, Public Health Journal, International Journal of Nursing Studies, and MEDLINE using the following keywords: 'peer supports,' 'peer navigators,' and 'peer outreach.' Researchers explored literature of PSS in non-traditional settings that focused on their roles, challenges, and supervision. Limited literature was found on PSS in non-traditional settings, resulting in peer outreach being evaluated. The searches were last

conducted on November 6, 2017. The evaluation team limited searches to articles that were written in English and that were Peer Reviewed.

Researchers have demonstrated that peer support is essential to a recovery-oriented and consumer-driven system, and that it influences the entire mental health system to be more recovery-orientated (Hermann & Palmer, 2012). Research has shown that PSS's in nontraditional settings should work together with other mental health professionals to implement care for clients. Throughout the research some common themes were found: the challenges and barriers faced through a PSS perspective, barriers and strengths in a non-traditional setting, job description, training, and adequate supervision.

Many researchers found different challenges and obstacles that were reported from a PSS's perspective. The first challenge was identified as PSS's perception and experiences of barriers that occur in the role of a peer in mental health services. In a comprehensive literature review, Vandewalle and colleagues (2016) examined 18 articles in traditional behavioral health settings and found that PSS perceptions and experiences cover a range of themes, including a lack of credibility of PSS roles, professionals' negative attitudes, struggles with identity construction, cultural impediments, poor organizational arrangements, and inadequate overarching social and mental health policies (Vandewalle et al., 2016). Expanding on these themes, individual professionalism of PSS and towards clients are discussed based on quality of services. PSS's experiences are unclear, and they often have vague description of their tasks and duties. This lack of role clarity can induce frustration and confusion in fulfilling their position, and hesitancy in demonstrating their true potential (Vandewalle et al., 2016). PSS's indicate their role is undermined due to its lack of professional standards, and by the inadequate training and financial compensation. PSS's feel pushed to educate themselves, take on more responsibilities,

or follow general training (Vandewalle et al., 2016). Research has found that the main training for PSS focuses on communication skills with clients, applying lived experiences, and dealing with overwhelming emotions. The PSS's expressed a need for more training in self-disclosure, professional relationships, involvement with family members of PSS, workplace policies, and functioning in team meetings (Vandewalle et al., 2016). Computer skills and knowledge about outside resources is essential to PSS' success. A study conducted in the LGBTQ community hired four PSS's to work 15-18 hours a week. The PSS's provided focused support resources in rural areas to the LGBTQ population (Willging et al., 2016). PSS reported needing to be computer literate, have necessary skills of using word processing, and skills in navigating the internet and social media for additional resources (Willging et al., 2016). PSS's also report needing to be knowledgeable about community resources, particularly healthcare agencies and practitioners, and feel discouragement and discomfort when they were not familiar with the services needed for their customer (Willging et al., 2016).

Another aspect that PSS's found to be beneficial was training in cultural competency. A large web-based survey of 527 PSS's examined cultural competency of peer-run mental health support groups and programs. There was an emphasis on the perceptions of adults with psychiatric disabilities (Jonikas, Kiosk, Grey, Hamilton, McNulty, & Cook, 2010.) The survey asked questions about cultural competency barriers facing peer-run programs. People of different racial and ethnic minorities were more likely than Caucasians to elaborate that both the recognition of the need for and interest in attending cultural competency training is lacking in PSS programs, as well as information about the diverse composition of PSS program memberships (Jonikas et al., 2010). Among those who had never participated in peer support, people of color were more likely than Caucasians to feel they would not belong and believed

their languages would not be spoken in PSS programs (Jonikas et al., 2010). Caucasians, on the other hand, were more likely to cite a preference for professional over PSS, while nearly half of both groups indicated that the main reason for non-attendance is a lack of knowledge about PSS programs (Jonikas et al., 2010).

Some PSS report being affected by work-related stressors, such as sharing stories on a personal level and projecting themselves as more approachable than professionals (Vandewalle et al., 2016). They report experiencing distress when they shared too much of their lived experiences. This then further challenged their performance. Acknowledging this close involvement can trigger emotional distress and burnout for peers (Vandewalle et al., 2016). PSS report that emotional attachment to clients can result in going beyond personal boundaries regarding emotional involvement. However, PSS's feel discussing boundaries with clients should be vague because it could interfere with establishing a meaningful connection (Vandewalle et al., 2016).

When focusing on outside professional attitudes towards PSS's, they report being affected by professionals' attitudes and experienced stigma when professionals use disrespectful language and paternalistic treatment toward service users. PSS's felt self-disclosing experiences with mental illness can decrease how professionals respect and value their contribution (Vandewalle et al., 2016). Tensions can arise when professional staff and PSS have different beliefs or values when it comes to working with clients. PSS's reported that professionals did not support their informal approach, did not believe in its effectiveness, and can labeled it as unprofessional at times (Vandewalle et al., 2016). These negative attitudes towards PSS then contribute to some feeling isolated or not being an equal team member. The isolation can grow during team meetings in the work setting. During team meetings, professionals and PSS can

sometimes get into power struggles, particularly when PSS may have little understanding of clinical terminology (Vandewalle et al., 2016). These professionals might further be offering supervision to PSS, which is an important aspect of PSS professionalism and their ability to grow. It also presents another obstacle they face in the workplace. PSS's report the focus of supervision as inadequate and refers to the supervisor's emphasis on task performance rather than emotional concerns, boundary issues, and personal development (Vandewalle et al., 2016). When PSS connect their client with resources and have questions, it can be hard to ask professionals for help due to feelings of not pulling their weight (Willging et al., 2016). One study reports that mental health professionals and PSS should come together to address barriers to the implementation of PSS and to enhance the quality of services the PSS can provide to clients (Vandewalle et al., 2016). Other research found that the training and coaching received was beneficial to building their confidence in the role. Supervisors did help some PSS's by discussing and explaining reasonable goal expectations and boundaries the peers should be following in their role (Willging et al., 2016).

A study conducted by Gates & Akabas (2007), evaluated a pool of 18 social service agencies that provided mental health services in New York City and employed PSS. The study was conducted to evaluate what policies, procedures, and structures can be provided to support peers in mental health service systems. This was done through PSS, executive directors, human resource managers, and supervisor's perspectives. This study found four similar themes as the above research and was consistent with prior research and experiences; attitudes toward PSS, role conflict and confusion, lack of policies and procedures around confidentiality, and lack of support (Gates & Akabas, 2007). The study also acknowledged factors that could help reduce role confusion and conflict for PSS. The first area addressed was PSS recruitment, which

reported that role confusion becomes more difficult when agencies recruit PSS within their own client population (Gates & Akabas, 2007). How policies are related to staff and client relationships is also a factor that could be evaluated prior to incorporating PSS into an agency. At some agencies, PSS are not expected to abide by the same policies as non-peer staff. Agencies need to be mindful that PSS may be lacking work experience and understanding of policies or the implications for abiding by them (Gates & Akabas, 2007). Role confusion and conflict for PSS also stems from agencies having poorly organized job tasks for PSS from being told to go wherever they are needed, to lobbying, to counseling an individual (Gates & Akabas, 2007). Inadequate training and lack of communication is also a barrier reported by non-peers and PSS. Professionals at agencies voiced they were not provided with training on issues related to working with someone with a mental health condition and were unsure of the expectations for the PSS within the agency (Gates & Akabas, 2007).

Several implications were reported by Gates & Akabas (2007), for PSS and staff to be better integrated with mental health settings. Research states agencies need to first conduct an assessment to determine how prepared they are to employ PSS. Ensuring there is a formal orientation for all new hires including PSS and non-peers, education on policy and procedures, and training for non-peer staff as well to learn how to incorporate PSS in the agency's mission is a crucial component (Gates & Akabas, 2007). Agencies will need to be knowledgeable about recruiting PSS for the jobs identified and clarifying PSS' roles early on. On-going support to staff and non-peers will be required to maximize PSS inclusion, increase retention, and improve channels of communication throughout mental health agencies (Gates & Akabas, 2007). Overall, this study identifies how vulnerable PSS can be due to shifts in funding and temporary positions.

The literature supports the importance of implementing the strategies discussed to help PSS overcome organizational barriers to carry out their roles (Gates & Akabas, 2007).

While the above research focuses on peers in traditional settings, the following research focuses on PSS in non-traditional settings. Very few studies describe or evaluate the roles of PSS's in non-traditional settings, perhaps because this is a fairly new and innovative area of practice. Of the studies that do exist, the largest is an evaluation of the Project Liberty Peer Initiative (PLPI) program, which was a peer outreach initiative for individuals with psychiatric disabilities in post-disaster communities (Hardiman & Jaffee, 2008). As part of a mixed-methods evaluation, interview guides covered topic areas including outreach, support for PSS, long-term PSS's group meetings, personal growth, and staff and administrative issues (Hardiman & Jaffee, 2008). Recipient interviews and focus groups were held at the specific community sites where participants attended groups (Hardiman & Jaffee, 2008). Outreach was found to be a key strategy used to identify and connect with individuals that were disabled due to their psychiatric need after disasters (Hardiman & Jaffee, 2008). Implications for the use of similar outreach strategies in future disaster planning and service delivery are described (Hardiman & Jaffee, 2008). The PLPI program used media to create awareness to the public about the outreach workers and how to connect with them. However, their effectiveness in specifically reaching the population of individuals that were disabled due to their psychiatric needs in New York City was not evident. These disabled individuals may not have access to the media because it was reported that when clients would call the outreach program, the clients reported not seeing any advertisement for the PLPI before calling (Hardiman & Jaffee, 2008). It can be difficult to get the word out about peer outreach programs to populations that do not have access to computers, transportation, or television. They found that connecting face-to-face with the clients in non-traditional settings

was a strength in forming a connection (Hardiman & Jaffee, 2008). The PSS's also reported it was easier to go to settings that they were familiar with such as pizzerias, parks, or the street. When the PSS's felt more comfortable, it made the process of trying to talk to clients easier. Due to the PSS's seeking out clients in public areas the PSS's felt that the clients were often busy with their own tasks at the time of contact. The city of New York is very fast paced, and the PSS's would get a maximum time of fifteen minutes to engage clients. PSS reported that fifteen minutes was inadequate to accomplish outreach goals and saw a need for more in-depth helping opportunities (Hardiman & Jaffee, 2008). Alerting mental health providers and other community members to the presence of peer-delivered support services were reported successful.

In another study, Hispanic patients were recruited from methadone maintenance treatment programs to be trained as peer outreach workers, targeting migrant drug users residing in New York and New Jersey (Colón, Deren, Guarino, Mino, & Kang, 2010). After recruitment and undergoing 12 weeks of training, the PSS's were paired with another PSS's to conduct outreach. While some of these PSS's were still avid drug users, they could work independently with specific instructions to do the outreach in areas that were highly populated and, in the neighborhoods, where they lived (Colón et al., 2010). Even though some of the PSS's were still using drugs, it was important to continue the research, because most of the PSS's were well known in their community and people listened to them despite their chronic drug use (Colón et al., 2010). The New York City community-based outreach was primarily street-based, and in New Jersey, the focus was on specific locations where individuals congregated such as social service programs or shopping malls. The PSS's did not go into the streets and residential areas due to high police activity in New Jersey (Colón et al., 2010). The PSS's struggled towards the end of the project due to losing out on the income they had been earning, the structure to their

daily lives that was provided, and the opportunity to make positive contributions to their communities (Colón et al., 2010). The supervisor of the PSS's also reported the lack of supervision they received themselves and voiced that having the ability to consult with a senior clinician to discuss issues or concerns would have been helpful (Colón et al., 2010).

A similar study was done where researchers trained PSS's in rural areas in the fundamentals of mental health, outreach, education, and support for the LGBTQ population (Willging et al., 2016). Researchers found similar results and found it to be helpful after the study that PSS's will likely require ongoing training, coaching, and support. The training itself focused on needs assessment, solution-focused helping, suicide prevention, conducting presentations, negotiating communication conflicts, outreach, ethical decision making, and self-care (Willging et al., 2016). The PSS's consisted of youth coordinators who identified as transgender (male to female), a health educator who identified as a Native American mother of a lesbian daughter, an art gallery owner who identified as a White lesbian, and a business student who identified as a White gay man (Willging et al., 2016). Three had struggled with mental health or substance use issues in the past. The PSS's were sent into schools, clinics, hospitals, and a crisis centers with the training they had received to do outreach with the LGBTQ population and the community to assess mental distress (Willging et al., 2016). Both the PSS's and the peer coaches reported that the initial training fell short in preparing the PSS's to perform outreach and build resources within the community (Willging et al., 2016). The PSS's wanted to be perceived as "professionals" by others, to enhance their credibility but lacked training. Developing relationships with different nontraditional settings is important to be successful in helping the desired population (Willging et al., 2016).

## Summary

Mental health systems are beginning to recognize potential benefits of PSS's in recovery and improve care for mental health patients (Hebert et al., 2008). According to Schutt and Rogers (2009), the benefits of using PSS's in a workplace improves quality of life for clients and improves engagement and satisfaction with services. PSS's can also help individuals improve on their overall health including chronic illness and reduces the cost of services. PSS's are delivering services and supports to individuals in a nontraditional setting and can help to identify what additional supports would be useful to perform their roles more effectively. With suitable support, training and supervision, people with lived experiences of mental illness can provide meaningful psychosocial, emotional and practical support to other consumers (Lawn, Smith, & Hunter, 2008).

Identifying limitations and gaps in the literature can help with furthering the research that is needed. Gaps in the literature include knowing little about individuals in recovery and how that affects their ability to function in the role of a service provider (Davidson et al., 2006). This fact also tells us little about the relationship being developed between the PSS and client, based on the PSS's life experiences. Other limitations include how PSS's had different definitions of each program. One study found that the programs defined peers by a shared experience, instead of having lived with mental illness (Siantz, Henwood, & Gilmer, 2016). PSS's with mental illness are considered an inappropriate resource for these programs (Siantz, Henwood, & Gilmer, 2016). Another limitation found was that some surveys were only given to professional staff even though it was encouraged to have PSS's fill out the survey when evaluating the success and challenges of PSS's (Hebert et al., 2008).

Mental health services are working to meet the needs of their populations, but many programs report that they are still in the planning stages of including a PSS (Hebert et al., 2008). There is still evidence needed to promote the practice of PSS's to become evidence-based including models, manuals, training curriculum, and fidelity measures to better understand what PSS's are doing with their life experiences, under what circumstance, and to what effects (Davidson et al., 2006). However, the PSS movement from a historical and social justice perspective is about offering a different set of values, a different way of thinking about who is an "expert," and a different way of relating to people in a helping relationship. The relationship between PSS's and mental health professionals is something that society needs to be thoughtful about and aware of.

The researchers will explore the implementation of PSS at the DPL using the knowledge, gaps and limitations of the literature to determine the obstacles and challenges PSS are experiencing, how PSS are delivering services and supports to individuals in a nontraditional setting, and what additional supports would be useful to perform their roles more effectively. Overall, there is limited research on PSS in non-traditional settings. The major take-aways were based on peer outreach. Peer outreach had conflicting messages relating to the PSS's roles. Some peers found it useful to be working in non-traditional settings by having access to their population, whereas other PSS's felt they were put in unsafe situations. The literature also identified that PSS's need more clarification on their roles and encourages them to be provided with adequate supervision. This literature reviewed will be helpful for the CMWN and the researchers to build on the peer support program and the customers they serve at the DPL.

### **Research Question**

There is limited research around PSS's working in non-traditional settings and a significant need for eliciting perspectives and voices of PSS themselves in this area. The purpose of this evaluation is to explore the experiences and perspectives of PSS's working in a nontraditional setting at the DPL. This study will specifically answer the following research questions:

1. How do PSS's in nontraditional settings report engaging with and supporting individuals who are not accessing other traditional support?
2. What obstacles and challenges do PSS's encounter in a nontraditional setting? What obstacles do they encounter when interfacing with traditional healthcare and mental health organizations?
3. What additional supports do PSS's identify as potentially useful to engage in their roles more effectively?
4. How do PSS's describe the preparation, training, and supervision received for their role and what additional preparation, training, or supervision would be beneficial?

### **Methods**

This study is designed to explore the experiences and perspectives of PSS's employed by the CMWN at the DPL. Three overarching concepts for PSS's delivery of services were identified: PSS' perceptions of their roles, PSS' perceptions of agency's efforts to interface with PSS in non-traditional settings, and PSS' perceptions of training and supervision.

### **Variables and Concepts**

This process evaluation uses a qualitative method with semi-structured interviews to explore how PSS's perceive their roles and obstacles, how PSS's customers who are not

engaging in traditional settings, and how agencies could better support PSS's in performing their roles. Customer is a term used by the CMWN that is defined as the individuals accessing services from the PSS's at the DPL. Throughout the study, PSS's are defined as people with significant life experience pertaining to mental health, psychological trauma or substance use. These individuals have overcome and now utilize their experiences to help other individuals experiencing something similar. The study discussed PSS's in non-traditional settings. Non-traditional settings was defined as settings where a professional in the mental health field would not frequently be seen as working in their role, such as parks, libraries, street outreach, gyms, etc. Mental health agencies was another term frequently used throughout the research and can be defined as other professional service agencies in the community in place for people with chronic mental illness, addiction, and homelessness that provides assessment, diagnosis, treatment, or counseling. Given the limited research on PSS's in a non-traditional setting, this study provided an initial understanding of how the PSS's role is implemented and supported in non-traditional settings.

### **Sample**

The CMWN is a peer-run agency that serves a variety of populations by providing one-on-one support to people in different stages of recovery through emotional and social support, advocacy, hope, education and training, and mentoring. The populations served are diverse and vary across socioeconomic and ethnic segments of the metropolitan area of Denver. All five PSS's employed by the CMWN were eligible for participation and were invited to participate in the interview. Participants of the study were from the CMWN, located in Denver, CO. The PSS's were recruited through a flyer (Appendix A) that was provided to them by the researchers at a PSS's team meeting.

At the beginning of the research project the identified sample size was five peers employed by CMWN, instead there were four PSS's present for individual interviews. The four PSS's had been practicing in their role for less than one year at the beginning of the research project. The funding for PSS's came from the Recovery Support Services contract with the OBH. The PSS's receive training for their roles through a PSS certification which consists of an 80-hour curriculum. Following the initial training, PSS's engage in WRAP, which is a comprehensive plan that PSS's utilize for themselves and others. They engage in WRAP by identifying triggers and steps to move through difficult situations. The four PSS's currently working at the CMWN serve as the sample for this study.

### **Data Collection**

The researchers held a meeting with supervisors at the CMWN where they presented the research design, the goals of the research, and gathered feedback on conducting the interviews with PSS. From the meeting, the supervisor suggested that feedback from the PSS's would be valuable information for their agency. The PSS were not individually recruited, but they gained permission from the on-site administrator with the CMWN. Site access was granted through the administrator from the research site. The DPL site was chosen as the site to conduct interviews due to it being the primary environment where the PSS's work. The PSS's supervisor, Elissa, discussed dates and times in February 2018 that worked best for all four PSS's. Elissa then reported back to the researchers. There was a cover letter provided by Elissa to the PSS's for consent one week before the scheduled interviews. The researcher reviewed the cover letter on the day of the interview to further discuss the study, questions the PSS's had, the benefits and risks of participation, protections for privacy, anonymity, and confidentiality (Appendix B).

The interviews were conducted at the DPL in a designated room. The interviews were allowed during the PSS's normal work hours. Individual, semi-structured interviews were scheduled with each of the four PSS's currently working with the CMWN. Interviews were expected to last approximately 45-60 minutes. Two researchers conducted each interview, which was guided by the Interview Schedule (Appendix C). One researcher led the interview while the other researcher took notes to ensure credibility of the interview. The interviews were recorded by an audiotape and then transcribed after the interview for coding. Privacy of the PSS's was protected by having the interviews conducted in a private room at the DPL. The PSS's could leave at any time, they could elect not to answer questions, and they could end the interview prior to all the questions being addressed if they wished. Partial anonymity of the PSS's was offered by hiding their identity to the extent possible throughout the research. This was done by changing their names in the transcripts and altering any other identifiable data. To minimize potential risk to their reputation or employment, the researchers avoided asking targeted questions designed to elicit negative feedback about their current work environment. The researchers were mindful of the potential risks to "outing" workplace dynamics that could be threatening to colleagues or supervisors. Confidentiality of the interviewed PSS's was addressed by keeping the transcripts on a password-protected computer. The CMWN did not receive a copy of the raw transcripts to help ensure confidentiality of the PSS's. The researcher gave the CMWN and the OBH a report that summarizes the main ideas that come from completing all the interviews. There was not be an impact on the PSS' physical or psychological performance following the interviews, meaning there was no more than minimal risk associated with this study.

## **Measures**

The interview questions utilized for this study were adapted from prior research studies and feedback received from the CMWN on areas they felt needed further exploration with the peers at the DPL. Throughout assessing prior research in traditional settings, PSS's reported challenges around knowing their appropriate role, receiving supervision, and identified a struggle as working with other professionals and agencies. There has been little research conducted on PSS's in non-traditional settings, so the overall focus of this study was to explore PSS's experiences in this relatively unexplored setting. The researchers reported the information back to the OBH and CMWN to help improve their ability to support, utilize the peers appropriately and maintain the PSS's at the DPL.

The approach to developing the research questions was developed to engage the PSS's in discussing their insight and own experiences while working at the DPL. The questions were developed to understand the PSS's work day, who the peers engage with, how frequently, challenges in a non-traditional settings, challenges and comfort level related to working with other mental health professional and traditional setting, how the PSS's receive support, and what training is needed and beneficial to their role. The questions were developed due to a gap in the literature around these topics specifically in non-traditional settings.

The first research question: how PSS's in nontraditional settings report engaging with and supporting individuals who are not accessing other traditional support, were answered through section A during the interview. The second research question: What obstacles and challenges do PSS's encounter in a nontraditional setting? What obstacles do they encounter when interfacing with traditional healthcare and mental health organizations? The questions were answered by evaluating section B during the interview. The third research question: What additional supports do the PSS's identify as needing engage in their roles effectively was answered through section

C. The final research question was evaluated through section D which addressed the concern of how PSS's describe the preparation, training, and supervision received for their role and what additional preparation, training, or supervision would be beneficial for them. The data was evaluated for consistent patterns and themes across the responses by the research team.

### **Data Analysis**

Once the interviews were completed and transcribed into text, the information received was coded for themes and patterns and reported back to the OBH and CMWN. Coding was done through preparation of data files collected through the interviews with each PSS. Each researcher reviewed the raw data until they become familiar with the content and gained an understanding of the themes and events covered in the text. Researchers then created categories based on actual phrases the PSS's stated throughout the interview. If there was an overlap of coding or text, researchers allowed the text to be coded into more than one category. The researchers continued to revise and refine the text from the interviews to include subtopics and identify contradictory points of view and new insight (Thomas, 2006).

## **Results**

### **Context**

Throughout the research the researchers were utilizing the term PSS's to refer to peers, but during the interview process the peers informed the researchers that they identify as peer navigators. For the remainder of this report, then, the researchers will adopt the term used by peer navigators in this setting. Individual interviews were held at the DPL with four peer navigators. The interviews were conducted in an enclosed conference room on the fourth floor of the DPL. Security passed by the conference room every 15 minutes to ensure safety. During one interview security interrupted the interview due to an incident occurring outside the interview

room. The peer navigators entered the interview having prior knowledge and understanding of the interview and research conducted on the day of their interview. Two peer navigators appeared more reserved while the other two peer navigators were noticeably more comfortable, as evident by the length of the interview. Peer navigators appeared to be appreciative of the interview and research conducted and voiced enthusiasm to receive the results and outcomes.

### Description of Sample

Four individual interviews were conducted with four peer navigators at the DPL. Table 1 details the characteristics of respondents. Majority of CMWN respondents identified as female (3 out of 4 and 1 out of 4, respectively). All CMWN respondents reported being employed part-time (4 out of 4) and half were working as a peer navigator for a year or less. The length of time for each interview varied from 0-30 minutes to 30-60 minutes (2 out of 4 and 2 out of 4).

Table 1

#### *Respondent's Gender, Time at Job, and Employment Status*

Colorado Mental Wellness Network (N = 4)	
Variable	N
Gender	
Male	1
Female	3
Time at Job	
5-12 months	2
12-15 months	2
Employment Status	
Fulltime	0
Part-time	4
Length of Interview in Minutes	
0-30	2
30-60	2

### Research Question 1 Results

Table 2 summarizes themes that emerged from interviews across all the research questions. Research question 1 asked how peer navigators in non-traditional settings report engaging with and supporting individuals who are not accessing other traditional supports and settings. Data was gathered from sections A of the interview to determine how peer navigators perceive their tasks and responsibilities when working with customers. Throughout the interviews, 4 out of 4 of the peer navigators reported drop-in hours as a valuable part of their role to support and engage customers. According to respondent #1, drop-in hours are three hours per day on weekdays for customers to engage with a peer navigator to discuss their current life challenge or questions.

Of the respondents, 3 out of 4 reported connecting customers to resources as a priority to help support and engage the customers. Throughout the interviews, the respondents identified resources such as food stamps, ID's, and housing. Respondent #1, discussed 211 as a valuable resource that the peer navigators use if customers are looking for something beyond a meal, such as a food pantry. Ensuring the customers feel safe was identified by 3 out of 4 of the respondents as a means for supporting and engaging with the customers better. Outreach was also identified by 3 out of 4 of the respondents. Respondent #1, identified outreach tasks as, "basically looking for people who are in trouble or someone who looks like they need something. I would say 40% of our time is out there." Respondent #3 reported that "sometimes the librarians will call us from the children's library if there is something going on that they feel uncomfortable with, so I have been down there several times." An overall theme reported by 4 out of 4 of the respondents stated that they just never know or that the day to day tasks vary, but overall, resources, drop-in hours, safety, and outreach were identified as the priorities to engage and support the customers of the DPL.

Table 2

*Commonly identified themes in peer navigator interviews (N=4)*

	Description	# interviewees who mentioned it
RQ 1: Engaging with and supporting customers		
Drop-In Hours	3 hours per day on weekdays for customers to engage with peer navigators	4 out of 4
Day to day varies	Never knowing what to expect, day to day task change and vary	4 out of 4
Resources	Connecting customers to food stamps, ID's, and housing, etc.	3 out of 4
Safety	By providing a safe space and allowing the customers voice and concerns to be heard	3 out of 4
Outreach	Walking around the DPL in search of customers who are in need and ensuring rules of the DPL are followed	3 out of 4
RQ 2: Obstacles and challenges		
Resources	Not having appropriate resources and not knowing/learning all the resources	4 out of 4
Emotionally Draining	Frustrated because wanting to fix and know everything	4 out of 4
Beginning Stages	Feelings of being in survival mode, knowing where to connect customers, wanting to fix customers problems	4 out of 4
Untreated symptoms such as psychosis or schizophrenia	When customers are experiencing psychosis, being unsure how to treat them or help and feel it is more of a	2 out of 4

	social work role than a peer navigator role	
Interacting with traditional settings	Unsure if the professionals in the community completely understand their role as a peer navigator	2 out of 4
<hr/>		
RQ 3: Useful supports		
Self-Care	Sleep, rest, food, hanging with friends, and contacting family	4 out of 4
Safe Environment	DPL is a safe setting for customers and peer navigators due to security	4 out of 4
CAC Training	Certified Addiction Counselor Classes	3 out of 4
Outside Resources	Therapy, medication, 12 step fellowship programs	3 out of 4
Library Staff	Staff understanding and being knowledgeable of the peer roles	2 out of 4
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RQ 4: Preparation, training, and supervision received		
Comfortable	Feeling comfortable with their supervisor and peers for support	4 out of 4
Continued Training	Peers enjoy the trainings they are receiving, but hope on-going training continues	4 out of 4
Supervision	Done weekly with the two Social Workers for one hour once a week	4 out of 4
Training provided by the CMWN	WRAP program provided by the CMWN prior to engaging in their role as a peer navigator	3 out of 4
Informal Check-Ins	Supervisors asking, “how the day went” and giving the peer navigators an option to discuss concerns if they are present	2 out of 4
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**Research Question 2 Results**

Research question 2 refers to the obstacles and challenges peer navigators encounter in a nontraditional setting and assessed what obstacles they encounter when interfacing with traditional healthcare and mental health organizations. Data was gathered from section B of the interviews to analyze and determine the obstacles and challenges peer navigators are encountering. Resources were identified by 4 out of 4 of the respondents as an obstacle and challenge. Respondents identified challenges around resources as not always having the appropriate resource for customers. Respondent #4 stated, “not having all the resources available that our customers need” was the most challenging part about working in the library setting. Respondent #4 identified missing resources as housing and portable showers for the customers they are serving. The other respondents did not specify what additional resources they felt were needed, but instead discussed that familiarizing and learning about all the available resources was also a challenge identified. Respondent #2 stated, “I think getting to know the resources, and it’s not like I am fully educated on that because there are so many resources.”

Emotional draining was identified by 4 out of 4 of the respondents relating to the respondents wanting to “fix everything, know everything, having to see people suffer and knowing there is nothing I can do for them.” (Respondent #3). For example, Respondent #2 states, “the hardest part is the draining. It is very emotionally draining at times due to, just you know, crisis and really draining customers.” All respondents also indicated that the beginning stages of employment was a very difficult and challenging timeframe. Examples include Respondent #1 expressing “when we first came in it was like survival mode,” and “it wasn’t

always smooth sailing for me, when I first came in, I needed to learn a little bit more about where to connect our customers too” (Respondent #2).

Of the respondents, 3 out of 4 identified interacting with traditional settings as a positive interaction, but 2 out of 4 are unsure if the professionals in the community completely understand their role as a peer navigator in the DPL setting. The remaining 2 out of 4 stated they “do not feel discounted or discredited at all” (Respondent #2). Of the other 2 out of 4, Respondent #4 stated that they did not feel professionals in the community understood the peer’s role but expressed that that the social workers within the library setting “have been really good about explaining our roles with the library.”

During the interview process, 2 out of 4 of the respondents also reported engaging with customers with mental illness or psychosis as a challenge due to not always knowing what to do. For example, respondent #4 stated "when folks are experiencing psychosis I don't always know what to do. I think the more serious and persistent mental health issues. I have felt like if I can't work with a customer, the social workers need to get involved because it is more of a social work thing than a peer navigator thing.” Respondent #2 also stated, “when a customer comes in who is experiencing untreated symptoms from Schizophrenia. Just anything untreated that I don't know. I mean obviously we are not mental health professionals and we have a basic understanding of what some of those symptoms can look like, but when it gets a little nutty that's when I can start to feel a little uncomfortable." Although this is an obstacle or challenge identified, it is also important to bring attention to the fact, that 2 out of 4 of the peer navigators reported feeling comfortable asking the social workers for help in these situations.

### **Research Question 3 Results**

Research question 3 referred to additional supports peer navigators identify as potentially useful to engage in their roles more effectively. Information for research question 3 was evaluated through section C of the interview questions. Peer navigators recognized an outside resource and support as Certified Addictions Counselor (CAC) training, which 3 out of 4 are engaging in on their own time. Respondent #4 stated, "I found really early that training was really important. I started my CAC classes and supervision, and that has been really supportive. I just need to add things, what am I doing here I need to add things sort of outside, and the CAC thing would be one of them."

Three out of the four peer navigators recognized that outside resources such as therapy, medication, and 12-step fellowship programs are beneficial to their personal recovery. For example, Respondent #2 voiced "I can continuously get support through a 12-step fellowship program that I am involved in, and I have a lot of volunteer service work that I do for that." Four out of four of the peer navigators voiced positive feedback about the DPL as a safe environment regardless of it being a non-traditional setting. Additionally, 2 out of 4 of the peer navigators implied it is essential and beneficial to have the library staff understand and become knowledgeable of their roles. The other 2 out of 4 implied, "people who do the shelving only know what we do because their cubicles are there, but they really don't know and that's ok. I don't expect them to know what we do" (Respondent #4). The peer navigators appreciate the library staff learning about their roles through shadowing. Overall, all peer navigators feel that self-care is an important support to be successful in their position. Examples of self-care were identified by the peer navigators as, "an everyday thing, there's meds, therapy" (Respondent #1), "seeing a friend" (Respondent #3), and "rest after work" (Respondent #2).

#### **Research Question 4 Results**

Research question 4 addressed how peer navigators describe the preparation, training, and supervision received for their role and what additional preparation, training, or supervision they feel as beneficial. Data was gathered through section D of the interview questions to further assess training, preparation, and supervision. Of the peer navigators, 3 out of 4 mentioned that the training provided by CMWN before starting their role was helpful information to have. According to Respondent #2, "I feel like it just expanded my entire awareness for my own journey in recovery, but also just the training needed to interact on a daily basis with those who are experiencing life challenges." Check-ins and supervision were identified as helpful by 4 out of 4 of the peer navigators, but 2 out of 4 of the peer navigators voiced they preferred informal check-ins over formal check-ins. According to Respondent #3, formal check-in was defined as "tell me about something you learned today and something about yourself." Whereas, informal check-ins relate to questions around, "how they are doing and how was their day?"

A positive aspect that 4 out of 4 of the peer navigators recognized was feeling comfortable and supported by their supervisors and peers. For example, Respondent #3 stated, "the two social workers (names removed) are super supportive. The other peers were all very supportive of one another, very much where we can feel like if I can't handle something I can say OK and go to one of them and ask them for help." Overall all peers stated they appreciate continued training and would like to see this continue in the future. Respondent #2 expressed feeling that a mental health first aid course would be helpful and the CMWN training could have been longer. Whereas, Respondent #3 felt that the CMWN training was "very helpful and very interesting." Respondent #3 voiced appreciation around receiving a "motivational interviewing training at the end of the month."

## **Discussion**

### **Summary of Findings**

The purpose of this study was to provide valuable, first-hand feedback to CMWN about the experiences, barriers, and needs of peer navigators providing outreach and services at the DPL. As this is a new and innovative program, the peer navigators' feedback can contribute to a greater understanding and better development of the program. CMWN's goal is to grow the numbers of their peer navigators located at the DPL, so the initial feedback from peer navigators might serve to tailor training, support and supervision needs for hiring and retaining additional peer navigators in this non-traditional setting. More specifically, the results of this study provided information related to how peer navigators perceive obstacles and challenges, how services are delivered, how support can be delivered in a nontraditional setting, and what additional supports and trainings would be useful to perform their roles more effectively.

Results suggested that when it comes to the peer navigator's day-to-day activities and tasks they feel they are meeting the needs of the customers, but resources can become an obstacle and challenge in their role, due to their being a great deal of resources they need to learn, or the needed resources being unavailable. Housing and showers were briefly discussed throughout the interviews as obstacles in obtaining resources, but there was an unclear consensus on what exact resources are needed to make the peer navigators' roles easier. This could be an area that CMWN enquires more about to help advocate for needed resources. Drop-in hours, outreach, and connecting customers to resources were reported to be major roles for peer navigators in this setting, and appropriately reflects the aims set out for this innovative program by the CMWN.

With these results, it can be inferred that peer navigators are successfully working toward the goals of the CMWN to provide access and awareness to services and resources for the

customers in the DPL. Research suggests that if peer navigators have knowledge of resources, computer skills, and relationships with community partners, they will be more successful in their role. The peer navigators within the DPL have discussed the importance of these skills and has demonstrated positive impacts through these skills for the customers and the DPL. Working towards the goals of the contract is also done through outreach to reduce customers' interactions with law enforcement and ensure safety. For example, the peer navigators reported the importance of the DPL rules. The peer navigators enforced these rules by outreach that consists of waking up sleeping customers, so they are not getting removed from the library by law enforcement. The contract goals are also being met by utilizing and implementing evidence-based practice through ongoing trainings provided by the CMWN to the peer navigators on a monthly basis.

There was an overall consensus from the peer navigators that the role can be stressful especially at the beginning stages, but one aspect that made their role easier was being aware of resources and utilizing traditional settings to support customers. Examples expressed by the peer navigators included feeling like they are not "discredited or discounted" (Respondent #2) by professionals in traditional settings and having good enough rapport to refer the customers to a traditional setting, such as the Colorado Coalition for the Homeless, Stout Street Clinic and utilizing the Crisis Center. Although, the peer navigators reported utilizing traditional settings, they did not all feel the professionals within those settings understood their roles when referring customers. Peer navigators did not specifically identify additional supports needed for their role, but they all voiced the importance of self-care and continued training. Additionally, the peer navigators did not express a need for improvement around supervision but voiced a preference for informal check-ins versus formal styles of supervision.

### **Comparison to Prior Research**

Focusing on traditional settings, the prior research discussed peer navigators feeling lack of credibility, needing role clarification, wanting more training or having inadequate supervision. The research also identified peer navigators as needing to have computer skills and knowledge, and awareness of outside resources. During the interview process the peer navigators reported similarities and differences with the prior research in traditional settings. For example, peer navigators reported positive feedback around trainings they are receiving and did not voice a concern around not knowing their roles within the DPL. Having a clear role for peer navigators and adequate training was a major strength of the CMWN for implementing the peer navigators. Research around peer navigators needing computer skills and knowledge around resources coincides with what the peer navigators at the DPL also identify as valuable information to be successful within their role and to adequately help a customer.

Although there is a lack of prior research on nontraditional settings there were still similarities and differences found throughout the interviews with the peer navigators at the DPL. Outreach was conducted in both the prior research and reported by the peer navigators. The only difference was how this was completed within a nontraditional setting. Peer navigators at the DPL identified outreach as being conducted in what they felt was a safe environment, such as the park and walking throughout the DPL and children's library. This is an innovative and excellent idea for the CMWN to combine outreach with a safe and supported working environment. Whereas, outreach in the research was conducted in streets, neighborhoods, and unfamiliar settings which were deemed to be unsafe.

Supervision was another area within the research that was reported as lacking in nontraditional settings in the sense that the peers wanted more time with a professional to discuss

issues or concerns. Peer navigators in the DPL reported feeling that they have adequate supervision and support, which speaks again to the overall thoughtful structure the CMWN has provided for their new program. Overall, comparing the published research with the feedback received from the peer navigators shows that the CMWN appears to have grasped the gaps and needs that have created limitations in the effective use of peer navigators in other settings, and taken efforts to fill those gaps as they implemented a new peer-delivered program.

### **Limitations**

Limitations of the study include a lack of prior research on the topic, self-reported data, and time constraints. There is a lack of prior research on the topic of peer navigators in non-traditional settings. The information gathered for this research was based on prior studies of peer outreach and peer navigators in traditional settings. This was identified as an important gap in the literature that the present study contributed to filling. The peer navigator program is also a new addition to the CMWN team and the research conducted is the first step in evaluating the peer navigator program. One limitation of the study was around sample size. Initially there were five peer navigators scheduled to be interviewed. The research concluded with four peer navigators instead of five for the interviews, posing an even smaller sample size than expected. This limits the generalizability of findings. It is unknown how well our results might apply to peer navigators working in other settings, but the peer navigators at the DPL identified similarities of peer navigators in other settings around clear roles, training, and supervision.

The time available to research and interview peer navigators in non-traditional settings was also a limitation. Due to time constraints, the researchers were not able to measure change or stability of the peer navigators in their roles over a longer time frame. The researchers were not allowed to evaluate peer navigators in multiple non-traditional settings also causing a limitation.

Additionally, the researchers were not able to member check with peer navigators after the interviews and coding was completed. Member checking was not completed due to lack of time allotted for the research project.

Reflecting on the interview questions the researchers would have made changes to prompting questions related to self-care, as it did not directly elaborate on how well the peer navigators felt supported. The researchers traded richness and depth for quantity of questions and topics, due to being fearful of migrating too far away from the interview questions. The researchers also limited their prompting and probes due to being worried about time constraints. Being fearful of probing and asking questions that might be perceived as too sensitive was also a barrier of the researchers that contributed to lack of depth in results. The researchers would also reflect on skills that need improvements for future interviews, such as ability to display empathy to better engage the peer navigators more effectively. The researchers also learned that they need to work on controlling the conversation of the interview when a peer navigator gets off topic.

Although there was 60 minutes allowed for each individual interview, the researchers were not able to keep all peer navigators engaged for the whole duration, posing a limitation around lack of information received. Even with prompting and follow up questions some peers did not elaborate or share a great deal of information which resulted in the interviews ending prior to the 60 minutes. The researchers are unsure if some peers felt less comfortable sharing, whether they did not have as much experience and valuable information to share that related to the research questions, or if the researchers did not ask direct enough questions or provide enough prompting and probing for additional information. The study is based on self-reported data which means some respondents may have been embarrassed or hesitant to provide vulnerable details about their role. Biases can also affect the overall results of the study. Power

differentiation could also speak to the vulnerabilities the peer navigators faced when the researchers were trying to elicit information. This limitation speaks to areas within the research that could have been conducted differently and areas of improvement within the research. In future research, the researchers will also be mindful of power differential throughout the role as an “evaluator.”

### **Strengths**

While this study may have several limitations, it also has strengths including the agency’s willingness to allow researchers to engage in evaluation of the peer navigator program. CMWN’s willingness to engage in this evaluation created access to participants and a confidential space for interviews to be conducted. Optimism and willingness to share from the peer navigators was also a strength of this study, even though some peer navigators discussed more than others. The questions asked by the researchers went through several revisions and received comprehensive input and feedback from all group members and CMWN to ensure the questions were adequately reflecting needed information. By collecting qualitative data, CMWN has access to information on the peer navigator’s interviews allowing for adjustments and implementation for the peer navigator program and services as needed.

Another strength of the study was a multilayered process to ensure the credibility of the data analysis. Three researchers completed an inter-coding process after the interviews took place. Following this, the researchers came together to discuss common themes that were found within the coding process. It would be beneficial for additional information to be gathered with peer navigators or new peer navigators of the CMWN program at the DPL to provide more detail and answers from this study, but information collected through these interviews has laid a foundation for further research and brainstorming for service enhancements.

### **Study Implications**

Based on the findings of the study, there are several implications for CMWN's peer navigator program. The first implication is connected to continue training for peer navigators. As represented in the findings, peer navigators identified the importance of training. Providing ongoing training for all peer navigators is essential for the peer navigators to be successful and confident in their role. The peer navigators provided positive feedback around monthly training opportunities provided by the CMWN at the DPL, such as motivational interviewing, trainings around suicide, and mental health first aid and they would like to see this continue. The peer navigators were vague in stating what they would like in the future but spoke highly of the trainings they have received and are going to receive in the future. Although the peer navigators were vague in identifying the trainings for future development, a recommendation from the researchers would be for the trainings to become more individualized. Since each peer navigator has their own lived experiences they may not all find the same trainings as helpful or beneficial based on their prior knowledge and experience. Being mindful of the peer navigators individualized lived experiences, especially within the first three months of employment, can better support the peer navigators in helping customers with certain experiences that they do not feel as comfortable working with. Additionally, training should be a two-way street. Professionals should be educated about the new emerging role of peer navigators, while peer navigators should also receive training and education on what the expectations are of their role and boundaries.

CMWN could continue to conduct further research to better understand the customers' experiences when engaging with peer navigators. Since the interviews were limited in time and sample size, it does not allow for an overgeneralization of the findings from the research. Future

researchers should interview not only the peer navigators, but the professionals of the DPL and the customers to observe support received, gaps in their system, or areas of concern related to the program to gain a better perspective around peer navigators.

The study also suggests that supervisors need to be mindful of peer navigators during the first 3-4 months of employment due to this being a challenging timeframe. Mindfulness of the beginning stages can be done through additional “check-in’s,” supervision, providing general knowledge on resources utilized by the peer navigators, and trainings within that timeframe. Throughout these additional supports provided to the peer navigators within the first months of their employment, this time could also be a valuable timeframe to learn and assess with the peer navigators their triggers while working in the DPL setting. While the DPL is a safe environment for the peer navigators to conduct outreach, the peer navigators should not only be mindful of their triggers, but the triggers of their customers. For example, having security present is a support of the peer navigators but this could be triggering for a customer depending on their past trauma and current crisis. Overall, most of the feedback received from the peer navigators was positive information validating that CMWN is successfully implementing and supporting peer navigators in their role.

Based on these findings, there are recommendations for future research. It is recommended to continue to evaluate how peer navigators are implemented into nontraditional settings. More research is recommended specifically on how peer navigators define obstacles and challenges in nontraditional settings. There is still a gap in the literature and from the researcher’s findings on how to better support the peer navigators in their role in the first three months. It is crucial to provide future peer navigators with frequently utilized outside resources.

More research and clarity on peer programs in traditional and non-traditional settings needs to be conducted to help educate professionals in the community about the roles of the peer navigators and how they can be utilized professionally. The article, “*Library Expands Services to Accommodate Homeless, Mentally Ill*” is a positive start to providing the community with information on the newly found roles of peer navigators at the DPL and how they are supporting the homeless and those with mental illness (Campbell, 2018).

Implications for the field of social work include adding to the research and knowledge base of CMWN. Social workers should promote and facilitate research to contribute to the development and knowledge around peer navigators (Royse, Thyer, & Padgett, 2016). Research needs to continue to unpack what makes a peer a peer. Social workers have an ethical obligation to understand the importance of life experiences and how this helps to shape the roles of the peer navigators. Social workers can do so by advocating on all levels of social work to incorporate peer navigators into traditional and nontraditional settings.

### **Conclusion**

Recognizing that peer navigators are growing and developing within the field of social work will significantly influence how traditional and nontraditional agencies support those experiencing life challenges. The researchers are hopeful the data collected during this study provides the information needed for CMWN to maintain program fidelity or provide areas for growth. This information and research could provide the required data for CMWN and OBH to receive funding for the program and identify other needs of peer navigators and the customers they serve. This study aligns with the social work value of service by helping those in need and creating or offering services that may not already be in place for identified populations. The findings also reinforce CMWN’s mission to provide education and advocacy, to provide

opportunities for individuals to improve the quality of their lives and is giving back to the community through providing meaningful roles such as the peer navigators. Through the peer navigators, CMWN is also helping to change the perceptions of mental health and advocate for those in need.

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# Come Share Your Experience!

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*Have the opportunity to  
provide insight on your role  
as a Peer Support Specialist.*

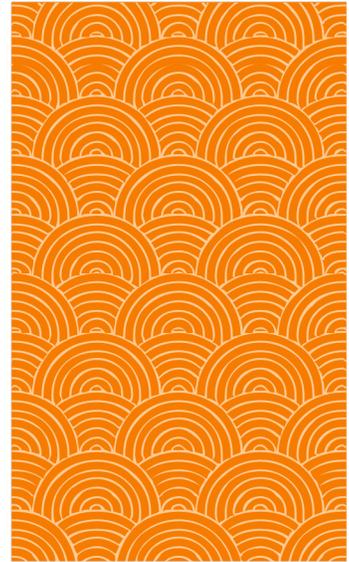
*A Starbuck's gift card will be  
awarded to each participant.*

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**Date**

**Time**

**Denver Public Library**



*Appendix B***Cover letter for Consent**

Dear Participant,

The following individual interview will be conducted by Master's level Social Work students at Colorado State University. As a peer support specialist employed by the Colorado Mental Wellness Network (CMWN), you are invited to participate in this individual interview.

The purpose of this individual interview is to provide valuable, first-hand feedback to CMWN about the experiences, barriers, and needs of peer support specialists providing outreach and services at the Denver Public Library. As this is a new and innovative program, your feedback will contribute to a greater understanding and better development of this program.

If you agree to participate, you will be asked to participate in an individual interview that will take approximately 45-60 minutes. For this interview, you will be asked questions about your experiences as a peer support specialist, your role, challenges you face, and supervision you receive. Your participation is completely voluntary. You may choose not to answer certain questions. You are also allowed to leave the interview at any time. At any point if you decide not to participate, your relationship with CMWN will **not** be impacted in any way.

**Confidentiality of Data**

Your name and information will not be used during the course of the study. Any recordings of the individual interview will be kept confidential, and reviewed by the primary researchers. All identifying information will be removed after the transcribing and analysis is complete. Your response will in no way impact your standing or employment with the CMWN.

**Audio Recording Policy**

The purpose of the recordings is to comply with Federal and State privacy laws and regulations for situations in which audio recording is used for ethical research conducted by CSU graduate research team.

1. Audio recording collected for research purposes will be maintained on a password protected Ipad. The Ipad will be kept in a locked safe, only accessible to the graduate research group team: Courtney Burgad, Amanda Pavlak, and Hannah Hoekstra. All students are currently enrolled in a Master's level program of Social Work and are supervised by Dr. Shannon Hughes, PhD, Assistant Professor of Social Work.
2. Audio recordings obtained will be transcribed. Your identifying information (like your name) will not be used in transcriptions. The findings will be delivered back to the Colorado OBH and CMWN, but they will not have access to audio recordings or written transcriptions, only to the final summary report.
3. Any copying, duplicating, or other forms of distributing audio recordings from the interview is prohibited. Only the original audio copy is allowed and will be destroyed within three weeks of the recording.

4. Your name will not be associated with anything you say during this interview. We might use some direct quotes from interviews to illustrate some of the main ideas. We will not use your real name even if we do quote something you said. However, since you are part of a relatively small organization, we cannot guarantee that others won't guess your identity

5. Consent form for audio recording is in addition to research participation consent form and the same confidentiality rules apply.

6. The following authorizes consent to participate in an audio recorded individual. interview.

***Consent for Audio Recording (for participants in focus groups).***

I \_\_\_\_\_, authorize the Colorado State University graduate research team to audio record during the interview for the purpose of conducting research on the peer support specialist program for the CMWN and OBH. I understand the audio record will only be used for research purposes and transcribed to provide feedback. After this research project, audio files will be destroyed. By signing, I understand it is my right to leave at any time during the research study and that I am over 18.

Thank you,

Courtney Burgad, Amanda Pavlak, and Hannah Hoekstra

If you have questions or concerns, please feel free to reach out to the Colorado State University graduate research member listed below.

Courtney Burgad

Email: [cjburgad21@gmail.com](mailto:cjburgad21@gmail.com)

Phone: 701-321-2175

*Appendix C***Interview schedule**

Greet participant, gift card to Starbucks, and direction to seats and room for introductions and agenda of interview. (5 minutes)

Once seated, thank participant for their time, introduce facilitator/observer, review agenda, explain recording, review cover letter, review purpose, and ground rules. (10 minutes)

**Purpose:**

We really appreciate that you took the time to join us today. We are passionate about providing a space for you to have your voice heard. We hope this is a useful experience for everyone involved, and will bring helpful information to CMWN to better support you in your role as a peer support specialist. We want to encourage you to be open and honest with your thoughts and opinions during our discussion. Our goal is to ensure confidentiality, but due to the small number of peer support specialist working here we cannot promise total anonymity. As far as what you can expect in the next hour, we will be asking some specific questions regarding your role as a peer. We look forward to hearing about these experiences. Thank you again for your willingness to share today.

**Individual Interview Ground Rules:**

Anonymity: Your name will not be associated with anything you say during this interview. We will not provide the CMWN or anyone else the full transcript of this interview. We will give the CMWN and the OBH a report that summarizes the main ideas that came out after completing all the interviews. We might use some direct quotes from interviews to illustrate some of the main ideas. We will not use your real name even if we do quote something you said. However, since you are part of a relatively small organization, we cannot guarantee that others won't guess your identity. That being said, it is okay to not answer a question. You can just say to me, "I'd prefer not to answer that" and we will move onto another question.

Also,

- There are no "right" or "wrong" answers. There's nothing we're "looking for" so there's nothing you can say that would be the "wrong" answer. We just want to learn about your own experiences and perspectives.
- Ask for clarification if you are confused or unsure how to respond.

**Introduction to Semi-Structure Interview Questions**

The researchers are CSU graduate students in the social work program learning about peer support specialist. The researchers are interested in your work as we believe it is valuable information related to our profession and you play an important role in helping others.

Today we will be exploring more about your experience as a peer support specialist. The prior research we have completed discusses peer support specialists in traditional clinical settings or

peer outreach, but today we would like to hear from you and more about your experiences as being a peer support specialist working in a non-traditional setting at the DPL.

### **Interview Questions:**

#### **Section A**

**Question 1: We are going to start off by getting to know a day in your life as a PSS's and the relationships you form doing that work. (15 minutes)**

1. When did you first start working at the CMWN?
2. Describe for me what a typical day looks like for you? Prompts:
  1. Who do you interact with?
  2. What kinds of general activities or tasks do you do?
  3. What are your main **priorities** on a typical day?
3. Walk me through how you might engage with someone at the library who you think might benefit from support or services.
  1. How many new customers might you interact with in a day or in a week? How many existing customers? How much time are you able to spend with customers?
4. Are you often interacting with other providers, like mental health clinics, healthcare organizations, or other traditional services? What's the nature of those interactions? Or What does that typically look like? (e.g., are you mostly making phone calls to services, meeting professionals and service providers in person, asking for information and making referrals?)
5. Describe for me what happens when you need to refer a customer for other services? Prompts:
  1. How comfortable do you feel with **knowing** where and how to refer?
  2. How comfortable do you feel **interacting** with providers of other services?
    1. How are you treated by professionals in other settings?
    2. Do you think other professionals understand your role? If there was anything you could educate other professionals on about peer specialists, what might that be?

#### **Section B**

**Question 2: We'd like to learn more about any challenges or obstacles you experience in your role, especially working in such a nontraditional setting.**

1. Think about the last year you have been in this role, do you feel your role has gotten easier or more challenging since you first began?

1. Were there things this last year that you found really surprising? What were those?
2. What were you expecting coming into this role? Were those expectations met or are there things that have surprised you?
2. What are the hardest parts of your job?
  1. What's most challenging about working in this setting specifically?
  2. Do you have any supports that you call on to get around some of those challenges you just named? Tell me about those.
    1. Follow-up: Are any of these challenges or obstacles being addressed by your supervisor? Do you talk to your supervisor about these things?
3. Has there ever been a time where you were in a situation with a customer or another professional that you didn't feel prepared for?
  1. Are there particular types of customers you feel more comfortable or less comfortable engaging?
  2. Can you describe for me a particular situation that you've run into that was challenging for you?
  3. [If they're able to describe an instance] Thinking back on that now, what would better prepare you to navigate that situation (or interaction or problem or whatever)? What additional preparation, training, or support could you imagine might make you feel more prepared to have that encounter again?

### Section C

#### **Question 3: We want to know how you are supported throughout your role as a PSS's.**

1. Who is a part of your support system as your role as peer professional? Prompts: this could include other peers you work with, your supervisor, other people in your life, etc.
  1. What kinds of supports do they provide? What have you found to be **most** helpful in supporting your work as a peer specialist?
2. Describe for me what supervision, in an ideal world, would look like. How often would you get supervision? Who would provide supervision? What would your relationship with your supervisor look like? What would your supervisor do that would be helpful to you?
 

What other resources or supports would be in place to help you do your job the best way possible?)
3. How do you take care of your overall wellbeing while taking on the role of a peer specialist? What's most important to your own self-care?

**Section D**

**Question 4: Now we would like to know more about your training process and if it is useful and beneficial to helping you and the customers.**

1. Tell me about the training you received prior to getting this job.
  1. How was it helpful in preparing you for what you're doing as a peer?
  2. What areas, if any, do you feel like you could use additional training around?  
How would that help you better in your role?

That concludes the individual interview, but before we end the session, is there anything else you would like to tell us about your experience with services at CMWN, or do you feel there is anything we might have missed that you think we should know? If you would like to receive a copy of our findings, please contact the supervisor (Elissa). Results will be available Mid May.