

**Recovery to Practice  
Curriculum Outline  
Final Draft**



**National Association of  
Peer Specialists**

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Recovery Curriculum Outline**

# Recovery to Practice (RTP)

## National Association of Peer Specialists Recovery Curriculum Outline

### Executive Summary

The Recovery to Practice (RTP) Initiative<sup>1</sup> is a 5-year project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), Office of the Associate Director for Consumer Affairs, to translate the vision of recovery into the concrete and everyday practice of mental health professionals of all disciplines.

Based on an analysis of the current state of the emerging and rapidly growing profession of peer specialists<sup>2</sup>, with an emphasis on gaps in skills and knowledge on the fundamental principles of recovery, the NAPS RTP team has drafted this outline for a proposed recovery curriculum *for working peer specialists*. The outline establishes a series of goals and learning objectives to help address the identified knowledge gaps and it provides a common foundation of understanding for working peer specialists to put the fundamental recovery principles into practice.

Included in this outline are statements about the purpose, scope, objectives, topics, core values, delivery methods, evaluation strategy, and core team members who are expected to be involved in the design, development, and review of the curriculum. *All are subject to change as lessons are learned during the content development and pilot testing of the training.*

### Introduction

#### ***Background: Consensus Statement on Recovery***

On February 16, 2006, the Substance Abuse and Mental Health Services Administration (SAMHSA) unveiled a consensus statement outlining principles necessary to achieve mental health recovery. The consensus statement<sup>3</sup> was developed through deliberations by over 110 expert panelists representing mental health consumers, families, providers, advocates, researchers, managed care organizations, state and local public officials and others.

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<sup>1</sup> A description of the Recovery to Practice (RTP) initiative is available at: <http://www.yale.edu/PRCH/research/rtp.html>

<sup>2</sup> The terms peer, peer specialist, and partner are defined in Appendix A at the end of this document.

<sup>3</sup> The SAMHSA Consensus Statement on Recovery is available at SAMHSA's National Mental Health Information Center at [www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4129](http://www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4129) or 1 (800) 789-2647.

The SAMHSA Consensus Statement defines mental health recovery as "a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential." The statement includes 10 fundamental components that enhance and enrich mental health recovery: self-direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, responsibility, and hope.

*"Recovery must be the common, recognized outcome of the services we support," said SAMHSA Administrator Charles G. Curie. "This consensus statement on mental health recovery provides essential guidance."*

### **Situational Analysis – RTP Peer Specialist Discipline**

In April of 2011, the National Association of Peer Specialists' (NAPS) issued a Situational Analysis report<sup>4</sup> to the Recovery to Practice (RTP) discipline partners on the current status of the peer specialist profession.

*Because the peer specialist profession is a relatively new phenomenon in mental health services, it is often unknown or misunderstood by other mental health professionals, medical health professionals and the general public. Confusion and misunderstandings also exist in regard to the roles peer specialists can or should play in mental health services.*

This outline for a proposed NAPS Recovery to Practice (RTP) recovery curriculum follows more than a year of evaluation of existing recovery resources and the working knowledge of peer specialists' working in a wide variety of settings<sup>5</sup> who are attempting to put recovery principles into practice, with varying degrees of success.

Through almost overwhelming input from peers, peer specialists, and partners<sup>6</sup> obtained from listening sessions, e-mails, phone calls and letters; and literature research, the NAPS RTP team developed the comprehensive RTP Peer Specialist Situational Analysis as a first step in understanding the current needs additional training and support.

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<sup>4</sup> The NAPS RTP situational analysis can be obtained as a free download from the NAPS website: [www.naops.org](http://www.naops.org) or by requesting an electronic or "hard copy" by e-mailing your request to: [stevch@naops.org](mailto:stevch@naops.org).

<sup>5</sup> Settings where working peer specialists provide services include inpatient units, forensic units, ACT teams, VA hospitals, bridger programs from hospital to community, and a variety of community-based programs.

<sup>6</sup> The term "partners" includes those with an interest in peer support development and sustainability. They include mental health professionals from other disciplines (including psychiatrists, psychologists, psychiatric nurses, occupational and recreational therapists, and social workers), family members, mental health organization administrators and those who receive or have received mental health services, heretofore referred to as "peers."

One finding was that peer specialists understand recovery based on their own experience, but encounter significant barriers when attempting to deliver recovery-oriented services. Many of the organizational and system barriers are beyond the scope of a fundamental training in recovery principles, but the training can help peer specialists better advocate for change as they encounter the larger system issues and barriers.

The main purpose of this outline is to summarize the findings of the situational analysis and keep the proposed training focused on just those important few gaps in skills and knowledge that can be addressed within a 2-3 day training format. The intent is to give peer specialists greater skill in putting recovery principles into practice in those areas where they have control or influence, and to open the door to a larger dialog with more recovery partners on the larger issues.

### ***Moving from Analysis to Design***

Over the year of analysis, the NAPS RTP team collected, evaluated, and organized a wealth of recovery resources that include books, brochures, booklets, DVDs, CDs, newsletters, professional journal articles, blogs, listserv and web site postings, and other materials that have been freely offered as resources for the development of this curriculum.

Although, to some extent, the process of gathering information and input will continue throughout the RTP project, the NAPS team is now moving toward curriculum design and development with the creation of this outline. Although it was originally thought the content for the curriculum and reviewer input would come primarily from a well-defined advisory group, the enthusiasm and demand for inclusion by peers, peer specialists, and partners alike quickly made such an approach unfeasible.

To promote inclusion and diverse perspectives, draft materials are being posted on the NAPS web site and an invitation to offer comments is sent by email to NAPS members and other interested parties. Although unwieldy at times, input from so many<sup>7</sup> is desirable as it fosters openness, accountability, inclusion, diversity and a better product. This kind of inclusiveness is also likely to result in greater “buy-in” among the various training organizations and peer and consumer organizations. Offering numerous opportunities for stakeholders to participate in the review and refinement of materials should lead to better training and implementation strategies and help to establish networks that will aid in the distribution of the recovery curriculum, helping to ensure its wide-spread acceptance, use and sustainability.

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<sup>7</sup> Input to the NAPS RTP situational analysis was provided by more than 50 peer specialists and partners, excluding those who participated in listening sessions conducted at various locations and settings across the U.S.

## ***Collaborative Curriculum Development***

The NAPS RTP team is now in the midst of developing more efficient methods<sup>8</sup> by which multiple partners and stakeholders can provide content and review input. In the initial stages, distribution of review material was by “hard copy” mailed to interested parties or as attachments sent via e-mail. Because of the cost and labor burden, the NAPS RTP is now investigating ways to enhance the use of the NAPS web site in conjunction with collaborative tools such as “Google +, Google Groups, Google Sites, and Google Docs” to allow multiple contributors to more easily collaborate, discuss content, and make and track changes in real time.

Hard copies will still be available upon request, as the team recognizes that not all interested parties have ready access to the Internet or skill with a computer. However, those prospective contributors who lack access to electronic means to review materials will be encouraged to take responsibility to pair up with others in their organizations or local communities who can assist them with electronic access to share their input.

## **Establishing Professional Standards and Values**

The U.S. Bureau of Labor Statistics defines an emerging career<sup>9</sup> as an occupation that currently has small numbers but that is expected to grow much larger in the future; many Healthcare careers fall into this category – including several titles that fall under the profession of peer specialist.

Because it is a relatively new profession, the NAPS RTP team found it necessary to take a “step back” and begin work toward a core set of professional standards for peer specialists. While other professions, through longevity, have long accomplished this task, the peer specialist profession is still emerging and maturing.

The articulation of a core set of professional values was identified as a key step in the RTP process by partners, so a small group of RTP team members and partners developed an initial draft of fundamental values. These values were posted on the NAPS web site with an invitation to offer feedback.

As one reviewer eloquently observed, “The core values need to be explicit, especially as peer specialists need to be the ambassadors and guardians of these values as they get implemented within interdisciplinary teams.”

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<sup>8</sup> A draft of this curriculum outline was posted on the NAPS website for review and comment. More than 30 reviewers responded to the email invitation and their comments were included in this final draft.

<sup>9</sup> In a recent article, The U.S. News and World Report lists several Healthcare careers as cutting-edge occupations that are available now and that will rapidly grow in the future. Among them are jobs that fall under the peer specialist profession: [http://degreedirectory.org/articles/What\\_are\\_Some\\_Emerging\\_Careers\\_in\\_Healthcare.html](http://degreedirectory.org/articles/What_are_Some_Emerging_Careers_in_Healthcare.html)

Most of the core values, such as self-determination<sup>10</sup>, were derived from the principles in the SAMHSA Consensus Statement and have been articulated in similar guidelines in recovery and peer specialist programs around the world. However, the development of a single, universal set of core values is an important step toward further recognition of the peer specialist as an equal professional discipline.

### ***Peer Specialist Core Values***

A peer support specialist is an individual who has made a personal commitment to his or her own recovery and is a role model for others. A peer specialist offers wisdom gained through personal experiences, sometimes known as “the therapeutic use of self” to inspire hope, support personal responsibility, promote understanding, offer education, and promote self-advocacy and self-determination. Peer support specialists are the ambassadors and guardians of the following values:

- Recovery is a choice.
- Recovery is unique to the individual.
- Recovery is a journey, not a destination.
- Self-directed recovery is possible for everyone, with or without professional help.
- Peer support is based on equality and mutual sharing between peer supporters and those they serve; power differentials are unhelpful and often damaging.
- Peer support is trauma informed.
- Peer support is open and curious about cultural beliefs, values, customs, and attitudes.
- Peer support is non-judgmental. Everyone has the right to be treated with dignity and have their individual human rights respected.
- Peer support is based on strengths, needs, preferences, and experiences.
- Peer support encourages relationships based on respect, honesty, and trust.
- Peer supporters do not exploit those they serve, or appear to do so.
- Peer supporters are knowledgeable about available community resources.
- Peer supporters stay current on new developments in wellness and recovery.
- Peer supporters are respected members of the recovery team, bringing a unique and valuable perspective from that of other providers.
- Peer supporters have their own supporters and model asking for help when necessary.
- Peer supporters are leaders, role models, advocates, and faithful servants to the principles of recovery; above all else, service to peers is the fundamental task of peer support.

The core values articulated in this outline will be used as the standards for the curriculum development and evaluation. All concepts conveyed will comport with these values and the conduct of instructors coordinated through NAPS for the RTP project will be expected to know and adhere to these values. The values will serve as both a foundation and guiding principles for the RTP recovery curriculum. These core values will continue to be refined throughout the development of the curriculum and subsequent training.

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<sup>10</sup> Multiple reviewers commented on the need for peer specialists and other recovery partners to have a better understanding of self-determination. Links to recovery resources such as the UIC Center for Self-Determination for more in-depth study will be provided at the end of each module: <http://www.cmhsrp.uic.edu/nrtc/tools.asp>.

## **Purpose of the Recovery Curriculum**

The recovery curriculum will serve the following purposes, as described in the situational analysis, through peer specialist profession-specific training:

- Fill recovery-knowledge gaps as identified in the NAPS RTP situational analysis.
- Provide a basis for acquisition of broader recovery knowledge.
- Facilitate continuing education initiatives.
- Encourage and promote career-long learning and curiosity.
- Improve and increase the recovery knowledge and practice base of peer specialists and thus improve services so they will be more effective.
- Serve as a basis for ongoing continuing education review to identify needs and respond to recovery knowledge gaps beyond the term of this project.

## **Scope of the Recovery Curriculum**

As described in the situational analysis, there are many approaches to training peer specialists. Different states have different standards, and some emphasize what is required to bill for services more than the principles of recovery and core values of peer support. When complete, the RTP recovery curriculum is intended to provide a fundamental understanding and common language for peer specialists in the key recovery topic areas identified in the situational analysis. It is not intended to provide comprehensive coverage, particularly in respect to policies for individual states or organizations, or to duplicate emerging curricula in for specific settings or specialized areas where peer specialists are providing services.

Currently, most working peer specialists are expected to obtain basic training in core knowledge and skills as defined by their individual states or organizations. However, specialty courses are emerging to enable this workforce to gain specific knowledge and skills in areas of particular interest and/or importance for a population that is being served.

Presently there are no universal standards to define how much training is required for a peer specialist to be considered competent meet a particular demand. For example, many peer specialist training programs offer an overview and some guidance (perhaps 2-3 hours) regarding how to facilitate supported employment during a 40 hour or greater core peer specialist training. But Boston University's Center for Psychiatric Rehabilitation is near completion and release of a "specialty" stand-alone vocational peer support course of approximately 30 hours in length. In this much longer exploration (nearly 10 times the length of a standard course), peer specialists will be able to build upon core knowledge and skills gained in prior, more general peer specialist training to specialize in facilitating vocational support.

The RTP recovery curriculum is designed to expose participants to a variety of topics, including specialty areas such as self-determination, self-directed care, wellness coaching, and vocational peer support. References within the training will give participants access to contact other organizations to learn more about their "specialty" programs. In this way, a broad audience

of peer specialists will gain a general understanding of specialty topics and have resources that will enable them to obtain further education in particular areas of interest.

Opportunities for pursuing further knowledge and will be included in each module. Fifteen minutes will be allotted at the end of each training module for questions, answers, debriefing, and further discussion about resources. Specific resources (websites, publication references, organizations, etc.) will be provided at the end of each module, but the allocated time will allow emerging specialty programs or local resources to also be discussed.

Due to project design and subsequent results of Year One of the RTP project, the recovery curriculum will be unique to the peer specialist profession. That means content, implementation, distribution and marketing strategies will unlikely conform completely to these aspects of other disciplines participating in the RTP project.

At the same time, the topics to be addressed in the NAPS RTP curriculum may be of great interest to other disciplines despite the specificity of curriculum design. It is important to note that, in many cases, recovery-related skills and knowledge are not unique to the peer specialist discipline. And for such topics as conflict resolution, a strong collaboration with the other disciplines will be necessary to address this issue most effectively.

Specific modules in the recovery curriculum, such as Strengthening Workplace Relationships, will be of great use for other disciplines as well. There may be opportunities during some training events for mixed groups of peer specialists and recovery partners from the other disciplines to participate in training together. Understanding expectations among all mental health professionals, and those they serve, will be fundamental to success in working together.

Thus, the curriculum will focus on the peer specialist practice but, at the same time, be cognizant that other disciplines may wish to attend training or otherwise use the curriculum. Language used throughout the curriculum manuals and the separate instructor guidelines will be carefully crafted to avoid an “us” vs. “them” approach.

## **Curriculum Review Team**

The NAPS RTP curriculum team will review the curriculum outline and all modules under development to ensure the content and activities meet the specified learning objectives. That team includes, but will **not** be limited to, the following:

- Steve Harrington is the NAPS Executive Director and principal writer
- Lisa Goodale is the Vice-President of Training, Depression and Bipolar Support Alliance (DBSA) and curriculum co-author
- Gladys Christian is the NAPS President and trainer with CenterPoint Human Services.
- Rita Cronise is an advanced level recovery educator, peer consultant, and instructional design consultant with over 20 years of professional writing and training experience
- Michael Roaleen, Director, Recovery Academy
- Antonio Lambert, Recover Resources Training Manager

- Dan Obrien-Mazza, Director of Peer Support Services, U.S. Department of Veterans Affairs
- Lynn Legere, Training Director, The Transformation Center

The above-mentioned individuals will offer comment on all drafted curriculum modules. As principle author, Steve Harrington will consider all perspectives and, as necessary, consult with co-author Lisa Goodale and other members of the team prior to approving the final approval by the main RTP project team and publication on the NAPS web site.

### **Curriculum Development Process**

After the outline is approved, the team will create a more detailed design document that further defines the purpose, scope, learning strategies, and specific measures (self-assessments, inventories or scales, observed role play behaviors) to tell if the learning outcomes have been successfully achieved.

Once the outcome measures have been established, then a content outline will be created that is focused on how the participants will successfully achieve the learning objectives (as they will be measured). The design document becomes the road map to keep all curriculum development activities on track and focused on accomplishing the learning outcomes as defined.

### **Development Time Frame**

The following is an aggressive estimated timeframe that anticipates a full pilot of the recover curriculum at the NAPS annual meeting in September of 2012. Concurrent design, development, test, and evaluation activities are shown in the calendar dates below.

October, 2011 – November 2011	<p><b>Outline approved / detailed curriculum design document developed</b></p> <ul style="list-style-type: none"> <li>• project management (roles, responsibilities, deliverables, dates)</li> <li>• learning objectives / competency tests (outcome measures)</li> <li>• map linking all content to specific learning objectives</li> <li>• overall structure (consistent for all modules)</li> <li>• format (templates for manuals, slides, and related deliverables)</li> <li>• review / approval process (determined for all modules)</li> </ul>
	<b>Initial Development</b>
November 2011	Draft Modules 1-2 / initial try out and review
December 2011	Draft Modules 3-4 / initial try out and review
January 2012	Draft Modules 5-6 / initial try out and review
February 2012	Draft Modules 7-8 / initial try out and review
	<b>Initial Review</b>
January 2012	Modules 1-2 / full review and alpha (pre-pilot) small scale test
March 2012	Modules 3-4 / full review and alpha (pre-pilot) small scale test

April 2012	Modules 5-6 / full review and alpha (pre-pilot) small scale test
May 2012	Modules 7-8 / full review and alpha (pre-pilot) small scale test

<b>Test Individual Modules / Components</b>	
April 2012	Test Modules 1-2 / pilot test draft (review comments incorporated)
May 2012	Test Modules 3-4 / pilot test draft (review comments incorporated)
June 2012	Test Modules 5-6 / pilot test draft (review comments incorporated)
July 2012	Test Modules 7-8 / pilot test draft (review comments incorporated)
<b>Pilot Test / Finalize and Deployment</b>	
August 2012	Final draft full curriculum / receive approval for pilot
Sept 2012	Pilot Full curriculum at the NAPS annual meeting in Philadelphia
Oct 2012	Integrate lessons learned from the pilot / final edits complete
Nov 2012	Full curriculum available for download on the NAPS web site
Dec 2012	Establish process for bi-annual review / updates from curriculum instructors and others (continuous quality improvement)

During the development phase, specific modules will be drafted and reviewed by peers or subject matter experts. For example, the module covering cultural issues will be reviewed by staff from the STAR Center, because they have expertise in this area.

Members of the target audience may be asked to informally “try out” and comment on portions of the training while it is being drafted. These early reviews by subject matter experts and members of the target audience will help to determine the amount of content and types of activities that are possible within the timeframes and other constraints. As much as possible, this kind of ‘field test’ should be done prior to a full scale review or pilot test. Pre- and post- training evaluations will be completed throughout all phases of development.

Process experts (those familiar with processes for developing effective training) will periodically review the curriculum to ensure the goals and learning objectives are being met through the team’s selection of content, activities, and other methods to inspire participants to build their skills and knowledge in the defined topic areas.

Draft modules will be posted on the NAPS web site as they become available for any interested party who wants to review and offer feedback on the curriculum.

## **Target Audience**

The target audience for the recovery curriculum has been identified as “working peer specialists,” Although it is expected that the curriculum will have broad appeal and use, including peers who are currently volunteers and hoping to ‘break in’ to the field, or non-peer coworkers and supervisors who are curious about recovery, the audience of ‘working peer specialists’ was identified because: 1) implementation will rely heavily on continuing education initiatives for working peer specialists who are (or will be) required to obtain such training, and 2) this audience, almost exclusively, has had training in core skills and knowledge and the curriculum will fit most easily in this context.

## ***Time Frame for Training***

The initial design of the recovery curriculum includes eight modules; each designed so (at a minimum) they can be delivered as instructor-led training within a standard 90-minute conference workshop format. Between set-up, introductions, questions, and any test or assessment at the end of each module, the standard conference workshop time frame of 90 minutes will likely yield less than 75 minutes of actual instruction and participation time.

While the conference workshop is one venue for providing this training, other venues (described later) may also be considered according to available resources. Blended training, in which small segments of the training are offered online, is an option that may be considered for the future, but most who are familiar with peer specialist training agree that the interpersonal and interactive elements critical to a successful training are lost when training is offered online.

Given the planned conference workshop delivery plan, the overall time frame for all of the modules combined (best case) will be 2 days. Of course, this will depend upon the number of modules actually implemented and the instructional format. Although modules will be designed to build upon each other for best learning, modules will also be designed to accommodate “stand alone” instruction on areas of special interest for a particular group, such as the module on “Strengthening Workplace Relationships.” Instructions for trainers will detail the value of teaching modules in sequence but the NAPS RTP recognizes that such an approach may not always be possible or practical, or appropriate for a given group.

During pilot testing, participants will be asked if pre-training could be used to supplement the recovery curriculum. “Homework” or assigned readings (or podcasts – or other forms of media) may be an option and the NAPS RTP team will seek creative, diverse ways to encourage pre-training education. To stimulate post-training learning, participants will be provided with references for additional study as part of each module. The evaluation process will determine the usefulness of such information. Other strategies to enhance post-training learning could include encouraging instructors to help participants establish local learning communities that they can use to hold each other accountable for continuing to develop skills gained in the training. In some places, local chapters of NAPS have formed that have become rich environments for peer specialists to come together and share informal ongoing lessons.

## ***Delivery Settings***

It is expected that the primary delivery setting will be at regional, state, or national peer specialist conferences. Such conferences offer peer specialists opportunities to connect or reconnect with experienced trainers who can use modules in institute and/or workshop formats.

Conferences of particular interest for implementation include the annual national peer specialist conference sponsored by NAPS and national conferences sponsored by organizations such as DBSA, the U.S. Psychiatric Rehabilitation Association, Alternatives, Assertive Community Treatment Association, and the Veterans Administration (VA). State peer specialist conferences are offered in Indiana, Michigan, Georgia, North Carolina, Pennsylvania and New Jersey. The city of New York hosts an annual peer specialist conference.

The NAPS RTP team has been approached by several states and the VA to use their annual peer specialist conferences as pilot testing opportunities.

Another growing trend is for organizations and groups to offer peer retreats or “advanced peer specialist training” courses. Because the NAPS RTP recovery curriculum will be available to download from the NAPS web site free of charge, a variety of organizations will be able to use the recovery curriculum to create a free-standing course to provide a refresher on some of the core concepts and to offer additional knowledge and skills from what peer specialists may have obtained during their core trainings.

Organizations will be free to use the recovery curriculum in whatever manner desired, including the use/production of DVDs, webinars, online training, training for other audiences such as non-peer co-workers and supervisors, family members, or others with an interest in the subject. Even though the recovery curriculum (as a public domain publication) will be free to download, any organization that adapts it for their own use will be able to charge whatever fee necessary and appropriate for providing instruction.

An analysis of each state’s peer specialist status and contact with state government officials is likely to identify additional opportunities and settings for curriculum implementation. This endeavor will be a focus of future NAPS activities and will be facilitated by the rapidly growing number of statewide peer specialist organizations formally affiliating with NAPS.

The recovery curriculum offers a potential career path for working peer specialists. Those with experience who successfully complete the training may become eligible to become trainers. Those who have been trainers within an organization could become eligible to become trainer trainers.

The main curriculum will be incorporated into two publications—instructor<sup>11</sup> and participant editions. The instructor edition will contain detailed instructions and recommendations for how to introduce, present, and summarize each module of training. The instructor edition will offer options to accommodate interactive elements and activities for various group sizes and settings. The participant edition will offer key points from presentations and space for notes to accompany specific activities.

Instructor manuals are expected to be “text heavy,” which means background behind the key concepts will be covered in detail so instructors can learn new material before teaching it. Instructors will have key points to use in presentations, with prompts to include their own personal examples, and clear instructions for participatory and experiential activities that they can adapt and use during the actual training.

The instructor manual will include detailed information about how to set up and lead role plays, small and large group discussions, and other types of activities designed to engage participants. The participant manual, by contrast, will contain an outline of key, activity worksheets or case studies, and room to take notes or write reflections about their experiences. Like the instructor manual, the participant manual will contain a section with related resources and links to websites, publications, organizations, and useful references.) For the participant, the manual will serve as a resource for further learning and to reinforce skills and knowledge learned through formal curriculum instruction.

Complete manuals will be available as free downloads from the NAPS website. The NAPS RTP team recognizes that all materials produced as a result of this project are public domain and that wide distribution of these materials best serves the purposes of the project.

An anticipated side benefit of the dissemination of this training is wide-spread discussion about specific recovery topics that connect enthusiastic peer specialist leaders who are passionate about social change and adept in using social media and other emerging collaborative technologies. Connections established in these training sessions could result in future innovations in recovery practices.

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<sup>11</sup> Some reviewers commented on the use of “instructor” or “trainer” as setting up the potential for a negative power dynamic. Some proposed alternate terms such as leader or facilitator to reduce the perception of power and privilege. For the sake of clarity, because the terms leader and facilitator also have multiple meanings that can have negative connotations or could be confusing to the reader, the familiar terms “instructor” and “participant” were used throughout. However, the discussion will continue, as the intended spirit for the curriculum is to establish a vital “learning community” in which all are invited to participate and share their wisdom within the constraints of time and group size. Within this learning community, the question of what to call the “instructor” will be a point of future discussion among the team and reviewers during curriculum development.

## **Registration Process**

Once the NAPS recovery curriculum becomes available for download on the NAPS website, individual organizations (including, in some cases, state and/or local government entities) will be responsible for handling the registration of attendees, securing a suitable location, hiring competent trainers, duplication of materials, set up of the classroom with computer projection equipment, internet access (if required), flip charts and markers (in sufficient supply), and a method for tracking those who have attended individual components of the training as well as those who have successfully completed the training.

Due to privacy/confidentiality issues, obtaining information on those who successfully complete the training to participate in long-term evaluation of the success of the training (as described later in this document) could present challenges if left solely up to the organizations that offer the training. Instead, NAPS could engage a group of authorized instructors who meet annually to provide contact information vital to long-term evaluation.

The RTP team will be clear regarding the intent (purpose/audience) of the curriculum but recognizes that, as a public domain document, the recovery curriculum will extend well beyond “control” of NAPS. This reality makes it vital that the curriculum design accommodates a variety of settings, skill levels and processes. A careful design will ensure some fidelity but the experience of even the most carefully designed initiatives has led to the conclusion by many that once such material is available on the Internet, “control” and use becomes an issue.<sup>12</sup>

In order to achieve a higher level of integrity, the NAPS project team will use its alliance with peer specialist trainers and training organizations to set a high standard for quality in the delivery of the curriculum and then work toward establishing a recognized credential that certifies a trainer as proficient and thereby a recognized/authorized trainer of the NAPS recovery curriculum.

Another method that could help ensure the quality of training could be to establish guidelines for becoming an “authorized” training provider. Individuals or organizations who commit to the quality guidelines could become “preferred partners” and be listed on the NAPS web site as authorized partners. Guidelines might include using NAPS qualified instructors and offering participants a way to report issues directly to NAPS if the training does not meet their needs or expected level of quality.

Data collection to track trends for continuous quality improvement will be provided through evaluations and feedback from instructors, participants, and organizations. A data collection mechanism could be set up on the NAPS website. Periodically, the data will be analyzed, improvement opportunities identified, and the curriculum revised to take advantage of new lessons and best practices. The website will be a focal point for input, review, and posting of future revisions to the curriculum and updated delivery strategies.

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<sup>12</sup> Rogers, E.S. (2011). Personal communication, July 10, 2011.

### ***Number of Participants***

Depending on the number of instructors, the ideal number of participants for each training session will range from 20 (for two instructors) up to 35 (with three instructors). More than 40 can become unwieldy and less effective – especially for role plays or small groups. But, as previously mentioned, there will be little or no control regarding the settings in which the curriculum is implemented once it is downloaded from the NAPS web site. To account for this, the curriculum will be designed in a manner that provides a variety of options for larger groups. For example, a highly interactive discussion for a group of 15-20 can become problematic for a large group of 50-100, but a similar discussion can be introduced in two steps where participants first discuss the topics in pairs or small groups and then a select few of the small groups report their insights to the larger group.

The NAPS RTP team will make recommendations regarding numbers of participants (particularly the ratio of participants to instructors) engaged in training sessions, and expect that “authorized” providers of the training will comply with these standards. However, as a public domain document, organizations will be free to adapt the training for a wide variety of purposes and needs. Thus, it is incumbent upon the NAPS RTP team to design a curriculum that is flexible and with diverse instructional options to account for not only the number of participants in particular sessions but many other variables such as culture, setting, environment and other contextual considerations.

Instead of diluting these essential recovery topics with a broad and vague “talking head” curriculum, the NAPS RTP team will incorporate role plays based on case studies to illustrate not only the value of cultural diversity but of geographical diversity and other types of issues as well. For example, a case study that describes how a Latino person may view wellness could become the basis for a compelling role play that not only engages participants in strategies for discussing wellness but stimulates discussion about cultural issues as well.

### ***Plans/Criteria for CEUs***

Each state with peer specialist initiatives is developing -- or has developed -- policies and protocols for continuing education units (CEUs). The importance of continuing education was identified by the Centers for Medicaid and Medicare Services (CMS) in a guidance letter issued August 15, 2007. Thus, states wishing to obtain Medicaid reimbursement for peer support services must provide a means for continuing education.

Although some states continue to struggle with the establishment of continuing education policies and protocols, it is interesting to note that it appears that the NAPS RTP project has renewed interest and commitment in this area. Thus, implementation of the recovery curriculum as part of continuing education endeavors appears more viable than ever.

Because obtaining CEUs from a licensing organization is a key requirement, the NAPS RTP team will ensure that the curriculum meets the basic criteria for CEUs from CMS as part of the development of the training.

While the NAPS RTP team will attempt to develop a curriculum that meets the CEU requirements for all states, the responsibility for modifications to meet individual state CEU development and implementation will remain with each state. If individual states require modifications to the recovery curriculum to meet CEU requirements, the NAPS RTP team will strive to make itself available to make such modifications or consult with states on ways to do so.

The NAPS web site may, in the future, host a learning management system (database) to capture and preserve essential data about the training – from who is doing the training, to what’s being trained, to who is being trained / has been trained (including those who have successfully or unsuccessfully completed specific modules as well as the entire training). It may also be used to provide templates of flyers, letters to stakeholders, hotel contracts, travel arrangements and other types of logistics to aid in the planning and dissemination of pre-requisite, training, and post-training materials, including ongoing evaluation of effectiveness.

## **Authorized Trainers**

It is expected that established and credible peer specialist training organizations will be the primary—if not exclusive—providers of instruction of the recovery curriculum during the pilot testing and early implementation. These providers already employ or contract with established and credible trainers who, with few exceptions, self-identify as peers.

The NAPS RTP team has developed a publication (soon to be published on the NAPS website) of guidelines for facilitating quality instruction of peer courses, such as the recovery curriculum. Once it is published, a commitment to follow the guidelines in this publication will be a pre-requisite for trainers to become qualified instructors for the NAPS recovery curriculum.

Although it is not practical in the long term for the NAPS RTP team to create a training workforce, it is possible—and appropriate—for the team to develop (or encourage the development of train-the-trainer instructor teams in the short-term. A national call for instructors is expected to attract many interested and highly competent participants. NAPS may create a database to coordinate the formation of a national training consortium for the RTP curriculum. Currently, NAPS publishes information about where and how to obtain peer specialist training on its website. It would be a complementary effort to include NAPS RTP instructors.

Coordination of RTP instructors can be accomplished through cooperation with several national mental health conferences that attract peer specialists (including the annual national peer specialist conference, DBSA’s conference, USPRA’s conference, Alternatives and others).

Because the recovery curriculum will be readily available and accessible, there will be no way to ensure that all organizations who download the materials will maintain fidelity to the curriculum design. However, as previously discussed, a process can be established for organizations to become “authorized” providers, which will require them to hire NAPS RTP training consortium certified trainers.

Fortunately, due to the manner in which peer specialist training has evolved, there is a large pool of established and credible peer specialist instructors who can become the trainer trainers for the NAPS recovery curriculum instructors. Access to these instructors is ensured through NAPS' network in the peer specialist profession. Potential partners in this aspect of the project include, but are not limited to: Recovery Innovations, Depression and Bipolar Support Alliance, Appalachian Group Consulting, Allied Service Providers of Indiana, Recovery Works, Mental Health America of Southeastern Pennsylvania, National Mental Health Consumers Self-Help Clearinghouse, National Council of Consumer Organizations, Boston University Center for Psychiatric Rehabilitation, Recovery Academy, Recovery Center of Hamilton County and state peer specialist organizations such as the Pennsylvania Mental Health Consumer Association. Federal partners include the Department of Veteran Affairs and NAZCARE.

## **Dissemination and Marketing of the Curriculum**

### *Dissemination*

The recovery curriculum will be available as a free download from the NAPS website. Other organizations are likely to provide a link to the NAPS website. In addition, for those peer specialists do not have ready Internet access, hard copies of the curriculum may be made available from NAPS. NAPS is likely to partner with peer-run organizations (in local locations) to create hard copies of the curriculum, or, if there is significant need for such documents to partner with a peer-run organization that can print in bulk and charge a reduced fee to cover the cost of production, shipping and handling.

### *Marketing*

Marketing started almost immediately after the RTP project began. The NAPS RTP began receiving requests for the recovery curriculum early in the project and demand has grown as the project progressed. Several peer specialist training organizations (Recovery Works, Affiliated Service Providers of Indiana, the Recovery Academy, and the Dept. of Veteran Affairs) have asked to be involved in pilot testing so as to be in a position to implement the curriculum as soon as possible.

Awareness of the recovery curriculum will be created through articles in the NAPS and DBSA newsletters, various listservs and through articles in such publications as SZ Digest, a national mental health publication with a readership of more than 125,000.

The NAPS RTP project team has created a list of partner contacts that will be specifically notified of the availability of the curriculum. This list includes the potential training partners identified previously who will do outreach to peers awaiting training.

Awareness of the availability and contents of the curriculum will also involve presentations at peer-oriented mental health conferences throughout the U.S. in addition to peer specialist-specific conferences. It is expected that, in addition to these efforts, dissemination and marketing will involve collaborative efforts with the other RTP disciplines, the Substance Abuse and Mental Health Services Administration and the Development Services Group.

## **Project Goals and Objectives**

The RTP project goals are:

- To create a peer workforce more knowledgeable and skilled in coaching and bringing recovery concepts and practices to the individuals they serve and the organizations that employ them.
- To enhance the abilities of peer specialists to inspire, encourage, educate and motivate those they serve to begin or continue their recovery journeys.
- To facilitate ongoing development of recovery knowledge, skills and practices through collaborative relationships with all recovery partners, access and use of recovery-oriented research reports, and an understanding of the relationships between recovery components, attitudes and practices
- To raise awareness about employment, education, and community integration opportunities.
- To promote social and community inclusion through establishing or rebuilding supportive relationships at home, in the workplace, in mental health service organizations and the community as a whole; further promoting individual and systems advocacy.

The proposed recovery curriculum modules, goals are:

- Module 1: Principles of Recovery
- Module 2: Acknowledging the Effects of Trauma on Recovery
- Module 3: Creating a Culture of Compassion
- Module 4: Strengthening Workplace Relationships
- Module 5: Peer Specialist Ethics
- Module 6: Recovery and the Whole Person
- Module 7: From Dual Recovery to Recovery of the Whole Person
- Module 8: Developing Supportive Relationships

## **Recovery Curriculum Learning Objectives<sup>13</sup>**

Throughout the curriculum, interactive and participatory teaching methods will be used. For both introductory and concluding activities, for example, role plays will be used to introduce topics and concepts and to stimulate discussion about what has been learned.

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<sup>13</sup> A note on the footnotes that follow: A variety of reviewers offered recommendations for the NAPS RTP curriculum team during the review of this outline. These and other resources will be referenced during the development of the curriculum.

Although the first goal and subsequent module was not specifically identified in the situational analysis, subsequent research and input has led the NAPS RTP team to believe a basic review of recovery principles is warranted to ensure that curriculum users/participants will be on the “same page” so that subsequent modules can be covered in a more coherent and effective manner).

### Module 1: Principles of Recovery

<b>Goal: To familiarize peer specialists with basic recovery principles.</b>			
<b>Learning Objectives</b>	<b>Content Outline</b>	<b>Format</b>	<b>Time Frame</b>
Define recovery	Brief overview of the RTP curriculum. Discuss recovery characteristics, words used in other definitions, group consensus	Large group discussion <sup>14</sup> using flip charts/white board.  Examining one's own recovery experience and developing a personal definition of recovery.	15 min.
Identify and define 8 of 10 recovery components and peer specialists' roles in recovery for peers	Review the Consensus Definition of recovery and each of the ten recovery components identified by SAMSHA in the context of peer specialist practice	Distribute SAMHSA recovery brochure. Small and large group discussions.	15 min.
Describe five ways recovery principles can be integrated into practice	Identify existing recovery-oriented practices used by participants, other practices that could be used and relate all to recovery components	Small and large group discussions and/or presentations on ways to integrate recovery.  Examples: Explain self-advocacy and how it relates to recovery  Tell a personal story that inspires recovery	45 min.
Identify three resources for more information <sup>15</sup>	List of websites, publications, and other media resources at end of module materials.	Large group discussion, debriefing, questions & answers	15 min.

<sup>14</sup> All group discussions—large and small—will involve minimal didactic presentation (only enough to guide the groups in purpose) and will involve extensive use of questions with interactive audience participation. Contributions by group members recorded on flip charts and/or white boards will be used to illustrate key points or to facilitate analyses during debriefing sessions.

<sup>15</sup> This is a tool for creating a self-determined plan for life [www.cmhsrp.uic.edu/download/sdlifeplan.pdf](http://www.cmhsrp.uic.edu/download/sdlifeplan.pdf).

## Module 2: Acknowledging the Effects of Trauma on Recovery

<b>Goal: To understand the importance and role of trauma-informed practices in peer specialist practice</b>			
<b>Learning Objectives</b>	<b>Content Outline</b>	<b>Format</b>	<b>Time Frame</b>
Define trauma and how unresolved trauma impacts the recovery process	Characteristics of trauma and traumatic events. What is our common understanding? What causes trauma?	Introduce topic and key concepts. Large group discussion. <sup>16</sup>	15 min.
Define trauma-informed practices and give examples	Basic practices, with examples, regarding specific practices	Large group discussion	15 min.
Identify three reasons why peer specialists should know about and use trauma-informed practices  Identify secondary trauma (compassion fatigue, burn out, and crisis prevention) as a part of self-care for peer specialists themselves	Review of Adverse Childhood Experience (ACE) study.	Large and small group discussions using hypotheticals.  Participants complete ACE survey.  Discuss what was learned and how practice can change.	45 min.
Identify three resources for more information	List of websites, publications, and other media resources at end of module materials.	Large group discussion, debriefing, questions & answers	15 min.

<sup>16</sup> One reviewer was concerned that a role play or other simulated example of trauma, particularly in a large group, might backfire and become non-trauma informed. Discussions were substituted for the earlier proposed role plays.

### Module 3: Creating a Culture of Compassion

<b>Goal: To understand cultural awareness and introduce relevant practices that facilitate multi-cultural effectiveness in peer specialist practice</b>			
<b>Learning Objectives</b>	<b>Content Outline</b>	<b>Format</b>	<b>Time Frame</b>
Define “culture” and “sub-culture” <sup>17</sup> and three possible cultural components  Discuss “nesting” or “overlapping cultures”	Description of beliefs (including different expressions of spirituality), values, language, customs, dress, rituals, and other characteristics, such as homelessness, poverty, and abuse that can comprise a culture.  Common experiences? History of oppression? Review of Marilyn Loden’s work.	Role play to illustrate cultural influences and how they can facilitate or obstruct effective services. Large group discussion  Include veterans, non-peer providers, and peers as distinct cultures to explore and understand.	15 min.
Describe two ways cultures develop	Geographic and social considerations, cultural evolution, why and how cultural diversity and disparity has contributed to our society	Large group discussion  Describe how recovery-oriented practices are sensitive to culture	15 min.
Identify three reasons why cultural “adeptness” (or “cultural curiosity”) <sup>18</sup> is important for peer specialist practice	Identify cultural groups each participant self-identifies, identify ways mental health services could/do conflict with cultures, identify ways peer specialists can approach cultural differences among peers and co-workers	Small and large group discussions	30 min.
Identify one way a trauma-informed practice may be applied to a specific cultural group	Value of recognizing and understanding own and other cultures, value of embracing cultural differences, detriment of judgment	Large group discussion using small group results. Role plays to review key concepts.	15 min.
Identify three resources for more information	List of websites, publications, and other media resources at end of module materials.	Large group discussion, debriefing, questions & answers	15 min.

<sup>17</sup> The VA Peer Support Training manual is a resource with information related to veteran culture.

<sup>18</sup> “Cultural curiosity” is a quality peer specialists can cultivate to remain open and learn about other cultures as a way to reduce judgment and open dialog with others.

## Module 4: Strengthening Workplace Relationships

<b>Goal: To ensure workplace inclusion through good communication and conflict management</b>			
<b>Learning Objectives</b>	<b>Content Outline</b>	<b>Format</b>	<b>Time Frame</b>
<p>Identify three ways to ensure ongoing collaborative learning, development, and recovery</p> <p>Measure progress as an organizational culture</p>	<p>Team framework – addressing fears associated with peers as part of workforce, boundaries, and working within policies and procedures that are not recovery-focused.</p> <p>Conflict resolution “toolkit” for peer specialists and those they serve, includes values clarification<sup>19</sup> and a self-assessment of power and privilege.</p>	<p>Large group discussion, role play to demonstrate real workplace conflicts and resolution potential.</p> <p>Practice working within a team framework with varied disciplines and points of view.</p> <p>Practice facilitating courageous conversations<sup>20</sup></p>	15 min.
<p>State three potential consequences of unresolved workplace conflicts</p>	<p>Co-optation, self-inventory, burn-out, termination,</p>	<p>Large group discussion</p>	15 min.
<p>Identify and describe two ways to handle differing opinions/attitudes among co-workers</p>	<p>Ways to educate co-workers, using personal experience, recognizing and understanding others’ perspectives, forming persuasive talking points, time-outs, mediation, value self-exploration</p>	<p>Small and large group discussions based on hypotheticals</p>	30 min.
<p>Describe how trauma and culture may play roles as barriers and facilitators to inter-personal understanding.</p>	<p>How and why organizations create own cultures, how own or others’ traumatic events may affect perspectives</p>	<p>Large group discussion. Role plays illustrating use of key skills and concepts.</p>	15 min.
<p>Identify three resources for more information</p>	<p>List of websites, publications, and other media resources at end of module materials. Distribution of conflict resolution toolkit.</p>	<p>Large group discussion, debriefing, questions &amp; answers</p>	15 min.

<sup>19</sup> A activity in the Toolkit on values clarification can help participants see what’s important to them is not always the same as what’s important to others as a first step toward conflict resolution.

<sup>20</sup> Boston University’s Facilitating Courageous Conversations uses a power and privilege self-assessment that is easily integrated into trainings, based on Peggy McIntosh’s work.

## Module 5: Peer Specialist Ethics

<b>Goal: To understand ethical standards and boundaries for peer specialists</b>			
<b>Learning Objectives</b>	<b>Content Outline</b>	<b>Format</b>	<b>Time Frame</b>
Define values (beliefs), ethics (behaviors) and the match between them (integrity)	Goal of ethical standards and boundaries—need to protect vulnerable people, nature of peer-to-peer relationships, motivations/passions that can cause problems	Large group discussion, role plays  Describe why ethical standards and boundaries are necessary and why they may be different for peer specialists than for other mental health professionals	15 min.
Demonstrate knowledge of real or potential ethical/boundary issues and identify at least three potential conflicts with peer specialist values	How issues can arise, discomfort they can pose for both parties, consequences of unawareness/appropriate practices, the dangers of becoming “too close” or not close enough to peers, confidentiality concerns	Small group exercises based on hypotheticals with role plays  Explain peer specialist responsibilities regarding “duty to warn” and breach of confidentiality.	45
Describe how trauma and culture may play roles in peer specialist practices as they relate to ethical and boundary issues	How inter-personal relationships may be perceived by peers, how topics discussed may make some uncomfortable,	Large group discussion, role plays	15 min.
Identify three resources for more information	List of websites, publications, and other media resources at end of module materials.	Large group discussion, debriefing, questions & answers	15 min.

## Module 6: Recovery and the Whole Person<sup>21</sup>

Goal: To understand why a holistic approach to peer support is important and how “holism” can be accomplished			
Learning Objectives	Content Outline	Format	Time Frame
Define “holistic” or “holism” and describe why a holistic approach is important for peer specialists’ practices	<p>Exploration of why peers are unaware of or ignore physical health issues, NASMHPD morbidity report, SAMHSA’s 10 X 10 initiative</p> <p>Holism beyond physical health (9 domains of wellness, including spiritual, sexual, and relationships)</p>	<p>Large group discussion</p> <p>Possibly tie back to ACE study (trauma)</p>	15 min.
List three ways a peer specialist can practice a holistic approach.	<p>Exploration of co-occurring health problems and causes, description of existing practices</p> <p>Include a segment on <b>Psychiatric Rehab</b> as a method and place for many, many resources</p>	<p>Role plays, large group discussion</p> <p>Evaluate personal beliefs and values about providing holistic services and how they could affect working with others</p>	30 min.
Describe how trauma and culture may play roles in peer specialist practices as they relate to practicing a holistic approach	Perceptions of various cultures to holism, perception/practices in U.S. regarding preventative medicine	Large group discussion, role play	30 min.
Identify 3 resources for more information	List of websites, publications, and other media resources at end of module materials.	Large group discussion, debriefing, questions & answers	15 min.

<sup>21</sup> One reviewer’s input: Recovery is what those of us with a mental illness do. Research has shown that the facilitation of recovery (i.e. practices) is highly effective when done from a psychiatric rehabilitation framework. As such, I think it’s critical that there be a module on what **psychiatric rehabilitation** is and how peer providers can use psych rehab practices to facilitate the recovery of their peers.

## Module 7: From Dual Recovery to Whole Person Recovery

<b>Goal: To understand the nature of co-occurring disorders and peer specialist practices that can facilitate dual recovery<sup>22</sup></b>			
<b>Learning Objectives</b>	<b>Content Outline</b>	<b>Format</b>	<b>Time Frame</b>
Define and describe what a co-occurring disorder is and the impact on recovery	Definitions of co-occurring disorders, define differences between substance abuse disorder and addictions  Place co-occurring issues in the context of the “whole person”	Role play followed by large group discussion	10 min.
State two reasons why co-occurring disorders arise	Stresses, environment, physiological explanations, recent research reports	Large group discussion	10 min.
Describe both “traditional” historic and recovery-focused approaches to helping people with co-occurring disorders	Meeting a person where they are, being non-judgmental, strengths perspective, resource connecting, seeking expert advice, roles of peer specialists  Include principles and practice of harm reduction.	Role plays followed by large group discussions  Differences between recovery for mental health and recovery for substance abuse such as abstinence (different views, values and approaches)	45 minutes
Describe how trauma and culture play roles in peer specialist practices as they relate to practicing a holistic approach	ACE study results, relate to holism, recent research reports, and how culture and trauma may affect exposure to substance use	Large group discussion, role play	10 min.
Identify three resources for more information	List of websites, publications, and other media resources at end of module materials.	Large group discussion, debriefing, questions & answers	15 min.

<sup>22</sup> VA Peer Support Training manual is a recommended resource for this.

## Module 8: Developing Supportive Relationships

<b>Goal: To understand how to develop more supportive relationships for themselves and in the lives those they serve</b>			
<b>Learning Objectives</b>	<b>Content Outline</b>	<b>Format</b>	<b>Time Frame</b>
Describe why relationships are important in general and to recovery specifically	Recent research reports that detail role of social relationships to mental and physical health, role of oxytocin (positive brain chemical related to overall health)	Role play followed by large group discussion  Explain how relationships may change over time and through the stages of recovery	15 min.
List three indicators of a healthy, supportive relationship	Mutuality, shared experiences, enjoyable group activities, personality types	Large group discussion	15 min.
List three ways a peer can meet people to form healthy, supportive relationships	Places within and beyond mental health settings, challenges of moving beyond comfort zones  Ways to support a peer who wishes to reconnect with family.	Large group discussion, role plays (if time permits, use of “human scavenger hunt” to demonstrate how such techniques can be used among peers).	30 min.
Describe how trauma and culture may impact peer specialist practices related to creating and building supportive social relationships	Importance of being non-judgmental, opportunities for personal growth and health, self-inventory, role of awareness of possible trauma and cultural considerations	Role play and large group discussion  Promoting Recovery Relationship Scale <sup>23</sup>	15 min.
Identify three resources for more information <sup>24</sup>	List of websites, publications, and other media resources at end of module materials.	Large group discussion, debriefing, questions & answers	15 min.

Scales and inventories to measure recovery (referenced below) are among the resources that will be used during the development of each module’s learning assessment to yield measurable outcomes on a module by module basis, as well as for the complete curriculum.

<sup>23</sup> Recovery Promoting Relationships Scale. <http://www.bu.edu/cpr/resources/newsletter/rprs/index.html>

<sup>24</sup> Measuring the Promise – a compendium of scales <http://www.power2u.org/downloads/pn-55.pdf>

## Competency Testing

Upon completion of each module, a competency test or assessment will be used to ensure that the learning objectives have been met. The instructor manual will provide a sample competency test for each module, but each state's requirements for CEU credit will determine the extent of the testing that is administered in each state.

Alternate methods of assessing competency (such as reading the exam, or having a translator read the exam) could be used to meet reasonable accommodations under ADA and ensure that differences in literacy, learning styles, language, and other issues such as test anxiety do not prevent otherwise highly qualified peer specialists from completing the training. Alternate assessments can also include interviews where participants describe how they have met the learning objectives, creative expression (drawing, skits, poetry) of the key concepts that were covered, or a demonstration of the skill learned in a particular module.

Over time, new competency tests and alternate methods of assessment may be generated by and shared at annual gatherings of RTP curriculum instructors. In these venues they will be able to compare experiences, make suggestions, and develop additional testing instruments. Logically, this gathering should occur in conjunction with the annual national peer specialist conference sponsored by NAPS.

In addition to competency testing, the pre- post-testing that will be in use for evaluating the effectiveness of the curriculum may be adapted to include alternate methods of assessment to determine the long-term effectiveness of the curriculum with more diverse populations.

Guidelines for scoring of competency tests will be included as part of the curriculum manual but, ultimately, this will fall under the responsibility of the state-certifying entities and their specific needs for CEU credentialing. This is also a topic that can be addressed during annual meetings of RTP curriculum instructors.

A national registry or learning management system (database) to track all who have completed the curriculum (total or individual modules) would be of great value not only to those who complete the training, but those who might potentially hire them.

## Evaluation Plans

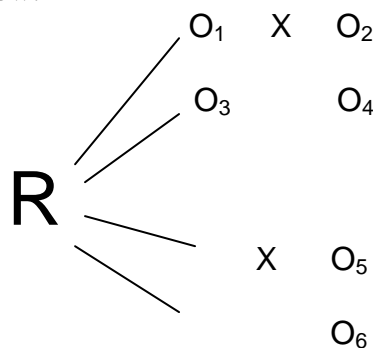
The curriculum will be evaluated (tested and improved) in stages throughout the development phase of this project, particular during the writing and pilot testing phases. During the writing phase, input will be obtained from review group members and partners. Comments and all other types of input will be incorporated as appropriate to allow for necessary revisions of format and content of the curriculum.

During the pilot testing phase, pre and post-testing will be used to evaluate the curriculum. These tests will provide both quantitative and qualitative data for analyses. In addition, naturalistic data gathering will occur, specifically, observations will be made by a NAPS RTP team member to determine how the curriculum is received by participants. An observation guide will be developed specifically for this purpose. Indicators such as attentiveness, questions, and both verbal and non-verbal reactions to instruction will be valuable.

At the end of each module, a large group discussion will be used to provide input on curriculum design. Finally, one-on-one interviews will be used to gather input about the effectiveness and propriety of the curriculum. Interview guides for those conducting the evaluation will be designed specifically for the large group and individual data gathering events. A brief demographic survey will be used to gather information related to culture, age, experience, education, etc.

Both quantitative and qualitative analysis will be used with narrative analyses used for qualitative analyses. A narrative and thematic analysis will be used for qualitative data.

Quantitative data will be gathered with the use of an experimental design. Specifically, a Solomon Four Group Design will be used to compare knowledge growth for a random sample derived from those who participate as participants (experimental group) and those who do not (control group). The design is illustrated below:



Note that “R” represents a random sample. “X” represents the “intervention,” in this case participation in the recovery curriculum. “O” represents “observation”, in this case, competency testing. An additional series of post-intervention observations (O<sub>7</sub> – O<sub>10</sub>) would help assess the long-term effects of the curriculum.

This evaluation design offers the following advantages:

- A focus on the “intervention.”
- Attention to confounders.
- Attempts to infer and not just describe.
- Controls all threats to internal validity.
- Controls for external validity threat of testing.
- Attempts to say X causes Y.

Although this evaluation regimen may seem complicated and unwieldy (and, indeed, it may prove to be so), the cohesive and cooperative nature of the subject population (peer specialists) is expected to overcome logistical and implementation barriers. This particular evaluation design was selected as it appears most likely to provide reliable quantified data and is likely to be especially suitable for peer specialists as testing itself may be a confounder. For example, testing may stimulate individual study by a subject as they become aware of a particular area of interest or need.

One way to implement this comprehensive evaluation is through the solicitation of volunteers to administer tests. Volunteers would act as research assistants trained in data collection to assure consistency in testing procedures and to facilitate contacts with subjects. Volunteers could be solicited and trained at successive NAPS or Alternatives conferences. In this way, peers could learn basic research skills and explore ways they may participate in social research in the future.<sup>25</sup>

Cross-tabulations and relational analyses will be used to determine whether specific learning objectives have been met, how learning can be facilitated, and where learning barriers exist and how they may be overcome. Indicators will be drawn from the learning objectives described as part of each module in this document.

Although there are no widely recognized measures for the effectiveness of peer support, such measures and instruments are currently under development. The NAPS RTP team will be monitoring the development of measures and instruments and, whenever possible, use those measures and instruments in the evaluation of the recovery curriculum and the profession. Some useful, related measures do exist, such as the Recovery Promoting Relationships Scale. That instrument and user manual have been acquired by the NAPS RTP team and will be of great assistance in program and professional evaluation.

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<sup>25</sup> See Linhorst, D.M. (2006). *Empowering People with a Severe Mental Illness: A Practical Guide*. Oxford University Press, New York and Morrell-Bellai, T.L., & Boydell, K.M. (1994). The experience of mental health consumers as researchers. *Canadian Journal of Community Mental Health*, 13(1), 97-110.

Evaluation will begin as each module is created in draft form. Further evaluations will be initiated during pilot testing. Although evaluation may be limited to short-term endeavors, long-term surveys may be used to gather longitudinal data to determine retention of key concepts by participants.

The completed curriculum will include evaluation forms that can be directed to the NAPS RTP team at any time to encourage additional input and determine future needs and necessary modifications.

## **Sustainability**

It is expected that the products and by-products resulting from this project will enjoy great longevity throughout the mental health care community and have a positive impact on communities in general. This will be facilitated by ongoing evaluations and input from peer specialists and the profession's partners. NAPS will dedicate a group of members and partners to regularly review the curriculum and make suggestions for modifications.

Through NAPS newsletter articles, curriculum users and others will be encouraged to provide input that will be used to further refine and improve the curriculum. NAPS will commit to making necessary resources available beyond the RTP contract term to accomplish sustainability.

## **APPENDIX A - GLOSSARY**

**Peer:** Any individual living with mental health, behavioral, communication, or emotional challenges – including but not limited to substance abuse or trauma histories. It includes those who currently receive formal system services, those on an alternate path to wellness (such as 12 step or spiritual approaches), and those who are “yet to be connected” due to a lack of awareness or access to recovery-oriented beliefs and approaches.

**Peer Specialist:** Any individual living in recovery with mental illness and / or substance abuse and who provides peer support to others whom can benefit from their lived experiences.

**Peer Specialist Certification and Roles:** The term “peer specialist” is an umbrella concept used to describe different titles, roles, and responsibilities. Titles such as peer bridgers, peer coaches, peer specialists, peer advocates, peer counselors, self-help support group facilitators, and peer recovery facilitators are often used interchangeably with subtle differences and similarities between them. The certification of peer specialists varies from state to state.

**Partners:** The term “partners” includes those with an interest in peer support development and sustainability. They include mental health professionals from other disciplines (including psychiatrists, psychologists, psychiatric nurses, occupational and recreational therapists, and social workers), family members, mental health organization administrators and those who receive or have received mental health services, throughout this outline referred to as “peers.”

The National Association of Peer Specialists (NAPS): is a private, non-profit organization dedicated to the development of peer support in mental health systems. Founded in November 2004 by a group of peer specialists, the organization has quickly grown with members from every state. They strive to make a difference by educating the public. They believe peer specialists offer an often untapped resource to the mental health system. They strive to make peer specialists an important component in mental health treatment and advocate for better working conditions, compensation and the adoption of recovery practices.

The Depression and Bipolar Support Alliance (DBSA): The mission of the Depression and Bipolar Support Alliance (DBSA) is to provide hope, help, and support to improve the lives of people living with mood disorders. DBSA pursues and accomplishes this mission through peer-based, recovery-oriented, empowering services and resources when people want them, where they want them, and how they want to receive them.

## APPENDIX B – EMERGING HEALTHCARE CAREERS

### *Supplementary information to the Situational Analysis*

Some emerging careers in Healthcare are new specialties, and some creatively combine two or more fields of expertise into one career, as is the case when Healthcare and computer science combine to form the field of health informatics. Read below for some examples of emerging careers in Healthcare.

The U.S. Bureau of Labor Statistics, [www.bls.gov](http://www.bls.gov), defines an emerging career as an occupation that currently has small numbers but that is expected to grow much larger in the future; many Healthcare careers fall into this category. The U.S. News and World Report lists the following Healthcare careers as cutting-edge occupations that are available now and that will rapidly grow in the future:

- **Wellness coaches** go beyond personal trainers to focus not just on exercise, but the entire concept of wellness. They help their clients eat more nutritiously, stop smoking, limit alcohol and manage stress.
- **Patient advocates** help patients navigate through the Healthcare system. For instance, they may help make sure a patient's insurance company correctly processes and pays claims. Patient advocates may be consultants hired directly by patients, or they may be employees of hospitals and insurance companies.
- **Health informatics specialists** help develop expert systems that nurses and doctors use to make diagnoses and determine the best treatments. Health informatics combines Healthcare, computer science and information systems.

[http://degreedirectory.org/articles/What\\_are\\_Some\\_Emerging\\_Careers\\_in\\_Healthcare.html](http://degreedirectory.org/articles/What_are_Some_Emerging_Careers_in_Healthcare.html)