Briefing for PWSRCAC Board of Directors – September 2022

ACTION ITEM

Sponsor: Danielle Verna and the Information and Education Committee

Project number and name or topic: 6560 Peer Listener Training Phase 1

1. **Description of agenda item:** The Board is being asked to accept the report titled "Evaluation Report Peer Listener Program" by Purpose Driven Consulting dated August 2, 2022. The purpose of this project was to review and assess the PWSRCAC's Peer Listener Training Program and similar programs nationwide that promote peer-to-peer community support. The review included interviews with select PWSRCAC stakeholders that have previously been involved in the program. The contractors from Purpose Driven Consulting will provide a brief presentation summarizing their findings from the review and their recommendations for updating the program to reflect best practices given PWSRCAC's capacity and mission.

2. **Why is this item important to PWSRCAC:** PWSRCAC supported development of a Peer Listener Program after the Exxon Valdez oil spill to build community resilience in the wake of a technological disaster. See a summary of the PWSRCAC's initiation of this program and continued support through time in item 4 below. This current project is a first step in comprehensively updating the program to reflect the time that has passed since the Exxon Valdez oil spill, developments in the fields of mental health and community wellness, and the desire for community members to be prepared to provide peer support and active listening to promote social well-being during a technological disaster.

3. **Previous actions taken by the Board on this item:**

Meeting	Date	Action
Board	1/28/2021	Approval of Proposed FY2022 Projects to begin in FY2021: Approval of the following list of projects to commence in FY2021 along with corresponding budget modifications, and delegation of authority to the Executive Committee to authorize contracts as indicated: e) Approve Project 6560 – Peer Listener Training Literature Review in the amount of $10,000 to commence in FY2021. This project will encompass the first part of the Peer Listener Training project slated for FY2022, and that has a total budget modification from the contingency fund in the amount of $10,000.

4. **Summary of policy, issues, support, or opposition:** The Peer Listener Training Program started as part of a project called Community Impacts Planning (CIP). In November 1990, the newly formed Council adopted a socioeconomic baseline as a research priority, and in 1991, set aside $300,000 for CIP. Social scientist Dr. J. Steven Picou and his team had been in Cordova since August 1989 to study social impacts of the Exxon Valdez oil spill. Dr. Picou was a leading researcher in the field of disasters and mental health who later studied the effects of Hurricane Katrina and the BP Deepwater Horizon oil spill. Initial work in the PWS region included evaluation of impacts in Cordova as compared to the control community of Petersburg. The Board approved an additional $174,750 in

1995 to continue work with Dr. Picou developing a training program, which included the (eventually-titled) “Coping with Technological Disasters – A User Friendly Guidebook” and a peer listening program.

The first Peer Listener Training debuted in Cordova in 1996. In 1999, the first edition of the Coping with Technological Disasters Guidebook was completed, which included a Peer Listener Training Manual within the appendices. By 2001, a video training for peer listener was available, which underwent a series of upgrades and releases in 2003, 2005, 2009, and 2010. In 2010, it was also made available on the Council’s Facebook page as a set of nine videos (11-18 minutes each). Records are unclear how many times the training was provided to an in-person audience, but trainings were given in 1996 in Cordova, 2001 in Anchorage, 2008 in Cordova. In 2016, the first-ever Train-the-Trainer program was held as a two-day, in-person event in Anchorage. Of note, the content for Train-the-Trainer program was largely the same, however the participants were professionals with training in mental health, including counselors, social workers, clergy, and professional educators. Dr. Keith Nicholls led this workshop, as Dr. Picou had retired.

In 2021, the Coping with Technological Disasters Guidebook was re-released after significant review and update. The Peer Listener Training Manual was identified as timely for additional in-depth revision, considering the extent of advancements in the field of mental health and community wellness since its original authorship. Until the Peer Listener project is completed, the Guidebook now includes a placeholder for the manual, which provides an introduction and background information on the original program as well as resource links for those looking for additional information.

5. **Committee Recommendation:** The Information and Education Committee has reviewed this work and made a recommendation for the Board of Directors to accept this report via email vote finalized on August 8, 2022.

6. **Relationship to LRP and Budget:** Project 6560 Peer Listener Training is in the approved FY2023 budget and annual workplan.

6560--Peer Listener Training
As of July 31, 2022

FY-2023 Budget	
Original	$25,000.00
Modifications	
Revised Budget	$25,000.00
Actual and Commitments	
Actual Year-to-Date	
Commitments (Professional Services)	$4,500.00
Actual + Commitments	$4,500.00
Amount Remaining	$20,500.00

7. **Action Requested of the Board of Directors:** Accept the report titled "Evaluation Report Peer Listener Program" by Purpose Driven Consulting dated August 2, 2022 as meeting the terms and conditions of contract number 6560.22.01, and for distribution to the public.

8. **Alternatives:** None recommended.

9. **Attachments:** The report titled "Evaluation Report Peer Listener Program" by Purpose Driven Consulting.

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Evaluation Report
Peer Listener Program

for

Prince William Sound Regional Citizens' Advisory Council

Completed by

Purpose Driven Consulting

Bianca Vazquez

Meghan Sobocienski

Maureen Okasinski

August 2, 2022

Contract number: 6560.22.01

The opinions expressed in this PWSRCAC-commissioned report are not necessarily those of PWSRCAC.

Abstract

With developments in the field of disaster response and peer listening, and the extended time since the Exxon Valdez oil spill, the Prince William Sound Regional Citizens' Advisory Council (PWSRCAC) committed to updating their Peer Listener Program to fit current realities. This evaluation provides a comprehensive analysis of PWSRCAC's Peer Listener Program to improve program operation and generate new knowledge focused on its next iteration, building on its existing strengths and incorporating best practices from both academic research and active peer listening programs nationwide.

Using a participatory evaluation approach with PWSRCAC staff and volunteers, the team completed 1) a literature review, 2) semi-structured interviews with program staff from eight programs across the country and a review of program materials and training curricula from ten programs, and 3) semi-structured interviews with eight PWSRCAC program stakeholders. Pulling from the fields of substance abuse, mental health, and wellness peer listening programs, community-based psychological first aid, and local and national disaster response programs, the program scan produced three approaches for peer listening: 1) short-term, immediate disaster response, 2) longer-term, community-anchored programs to impact social cohesion and general well-being, and 3) a hybrid model of immediate and long-term disaster response to impact community resiliency.

It is in the self-interest of communities to invest in community and peer led disaster preparedness and response networks. A first step for PWSRCAC's revision is to select an approach and match their resources allocated with the goal and objectives of the program.

While the complete recommendations resulting from this project can be found in the corresponding section (starting on page 47), the high-level, key points are as follows.

Recommendation 1: Select an approach and design based on your desired impact and resources.

The PWSRCAC's Peer Listener Training Manual describes a program consistent with the ongoing, long-term disaster response approach that results in community resiliency. The program's stated goal was to train enough leaders so that the cohort of trained listeners can respond as a crisis team to disasters, continuously train community members as peer listeners, support a therapeutic community, and be available for subsequent disasters. This is consistent with both the stakeholders' vision and with best practices in disaster response.

However, the challenge in the successful implementation of this approach is relationships and resources. To date, resource allocation has not matched with the program approach and scope as described in the manual and defined as priorities by key stakeholders.

Recommendation 2: Build relationships and create partnerships to accomplish program goals and execute selected program approach.

Part of the creative solution to the challenge is to build relationships for collaboration and partnership toward a coalition embodying shared values and objectives. Best practice peer listening models throughout our research indicated a clear lead organization and clear partnerships with well identified roles which may be well met by the establishment of a formal coalition to support peer listening programs. Consider that partnerships could provide opportunities for funding that these organizations could get for doing this work. PWSRCAC will need embedded leaders/community leaders as they revise program design and training materials. PWSRCAC will likely need to establish new relationships within its own communities and outside of them to do this.

Recommendation 3: Program Design–Peer Listeners

Once the approach and scope are confirmed and aligned, PWSRCAC can develop these aspects of the program:

a. Eligibility and recruitment of peer listeners
b. A plan for vetting and recruiting of listeners
c. A plan for maintaining relationships between listeners, as well as ongoing peer listener support.
d. Build a structured outreach plan to involve communities named as priorities.
e. Decide how peer listeners get connected to care receivers.

Regardless of the approach and scope selected, more support to peer listeners is required.

Recommendation 4: Program Design–Training Curriculum

There is a rich array of curriculum available to learn from and adapt to update PWSRCAC training curriculum. Within those resources, integration of the below considerations will increase the effectiveness and impact of the training:

a. Revise program design to formalize a peer listener support structure and ensure all aspects of the program are trauma-informed.
b. Rewrite the curriculum pedagogy to be at least 60/40 didactic versus role play in presentation and teaching. Increasing the active learning aspect of the training program will strengthen the retention of skills.
c. Separate any peer listener training program from the train-the-trainer program.

d. To fulfill the PWSRCAC's Peer Listener Program purpose, training must be more frequent as well as match program approach.
e. Make clear to peer listeners and in materials that peer listening is a skill to use in everyday life, and can be activated in a crisis or disaster. This everyday use addresses community resiliency and makes it possible for these skills to be more effectively used in a disaster.

Recommendation 5: Cultural competency and relevancy integrated at each stage of planning, design, implementation, and evaluation.

In order to expand the program's ability to reach more people affected by disasters we recommend and encourage broader community engagement with Alaska Natives and other members of the diverse communities in the next stage of program planning. We suggest investing in a community-integrated planning and implementation process to ensure that program design responds to geographic, cultural, and community diversity. This response would address another need identified by stakeholders, the literature review, and organizational interviews – that the program is reflective of and responsive to the 19 Alaska Native communities and the diversity found in the culture, professions, sizes, and distances between communities.

Recommendation 6: Develop program monitoring and evaluation

One of the biggest gaps we uncovered in the field of peer listening and disaster crisis response was around evaluation. Nearly every program we interviewed desired more evaluation work and a greater understanding of the effectiveness of their programs and work. With PWSRCAC 's initial leadership in this field, we recommend the following as it continues to lead:

a. Develop a program quality assessment matrix consistent with PWSRCAC's self selected approach, design, and best practices.
b. Adopt a set of program monitoring (delivered activities and outputs) and outcome measurement tools.
c. Healthy partnership and cross community coordination assessment can aid in the ongoing retention of partners and resource development.

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A. Annotated Bibliography
B. Peer Listener Program Interview Questions
C. Organizational Interview Summaries
D. Stakeholder Interview Questions
E. Key Recommendations for Peer Support Programs

Peer Listening Program Resources *(available on request through PWSRCAC)*

a. NOVA-CRT-6 documents
b. Red Hook-4 documents
c. Stephen Ministries- 2 documents
d. UM CAPS Peer Counseling-3 documents
e. UM Peer-to-Peer- 3 documents
f. Vibrant-2documents
g. Psychological First Aid Field Ops Manual
h. Peer Counseling Toolkit Southern Plains Tribes
i. Psychological First Aid handout, SAMHSA
j. Psychological First Aid webinar slides, SAMHSA

Acknowledgements

The evaluation team expresses their gratitude for the contribution of time, knowledge, and experience from staff, volunteers, and Board members of the PWSRCAC, as well as to the staff of the organizations around the country working in peer listening and peer counseling. Their attention and generosity made this report possible.

Mississippi Alabama Sea Grant Consortium
Nova-CRT
Red Hook Initiative
Stephen Ministries
University of Michigan Counseling and Psychological Services Peer Counseling Program
University of Michigan Peer-to-Peer Program
Vibrant CETC

We'd like to note - It was particularly touching to interview the Mississippi-Alabama Sea Grant Consortium (MSGC) staff. The MSGC staff highlighted that the initial conversations with PWSRCAC alerted them to the reality that a technical disaster would bring significant community mental health challenges and allowed them to respond more effectively.

Evaluation Background

Program Overview

The Prince William Sound Regional Citizens' Advisory Council (PWSRCAC or the Council) is an independent nonprofit corporation whose mission is to promote environmentally safe operation of the Valdez Marine Terminal and associated tankers. Their work is guided by the Oil Pollution Act of 1990 and their contract with Alyeska Pipeline Service Company. PWSRCAC's 18 member organizations are communities in the region affected by the Exxon oil spill, as well as Alaska Native, commercial fishing, aquaculture, recreation, tourism, and environmental groups. All member entities were affected in some way by the 1989 spill, and all have a significant stake in the prevention of oil pollution and protection of marine resources in the area.

The Peer Listener Training Program started as part of a project called Community Impacts Planning (CIP). In November 1990, the newly formed Council adopted a socioeconomic baseline as a research priority, and in 1991 set aside $300,000 for CIP. Social scientist Dr. J. Steven Picou and his team had been in Cordova since August 1989 to study social impacts of the Exxon Valdez oil spill. Dr. Picou was a leading researcher in the field of disasters and mental health who studied both the Exxon Valdez and BP Deepwater Horizon oil spills. Initial work in the Prince William Sound region included evaluation of impacts in Cordova as compared to the control community of Petersburg. The Council Board approved an additional $174,750 in 1995 to continue work with Dr. Picou to develop a training program, which included the (eventually titled) "Coping with Technological Disasters – A User-Friendly Guidebook" and a peer listening program.

The first Peer Listener Training debuted in Cordova in 1996. In 1999, the first edition of the Coping with Technological Disasters Guidebook was completed, which included a Peer Listener Training Program Manual within the appendices. By 2001, a video training for the Peer Listener Training was available, which underwent a series of upgrades and releases in 2003, 2005, 2009, and 2010. In 2010, it was also made available on the Council's Facebook page as a 2-hour set of nine videos (11-18 minutes each). Records are unclear how many times the training was provided to an in-person audience, but at least in 1996 in Cordova, 2001 in Anchorage, 2008 in Cordova. In 2016, the first-ever Train-the-Trainer program was held as a two-day, in-person event in Anchorage. Of note, the content for Train-the-Trainer was largely the same, however the participants were professionals with training in mental health already, including counselors, social workers, clergy, and professional educators. Dr. Keith Nicholls led this workshop, as Dr. Picou had retired.

In 2021, the Coping with Technological Disasters Guidebook was re-released after significant review and update. During the revision process, PWSRCAC identified that it was time for the Peer

Listener Training manual to undergo in-depth review as a separate project, considering the extent of advancements in the field of mental health and community wellness since its original authorship. Until the Peer Listener project is completed, the Guidebook now includes a placeholder for the manual which provides an introduction and background information on the original program, as well as resource links for those looking for additional information.

Evaluation Purpose

To provide a comprehensive analysis of the Council's Peer Listener Program to improve program operation and generate new knowledge focused on its next iteration that builds on its existing strengths and incorporates best practices from both academic research and active peer listening programs nationwide. The evaluation will engage with current and former staff, volunteers, and Board members of PWSRCAC, individuals who attended prior Peer Listening training, and staff at other organizations who have used peer listening or a similar model to respond to community disasters, mental health, and well-being needs.

Evaluation Questions

1) What are the strengths and areas for improvement in PWSRCAC's current Peer Listener Program?
2) How can the PWSRCAC build forward from the existing programs strengths and areas for improvement using currently acknowledged best practices in a Peer Listener Program model and program models that meet similar needs through alternate designs?
3) How can the PWSRCAC incorporate relevant ethical and legal considerations effectively into its program design?
4) What potential partners can the program engage with to meet the region's unique needs, and what potential partners regionally or nationally could form a long-term network that keeps the program updated and relevant?

Evaluation Team

Purpose Driven Consulting is a collective of evaluators and community organizers with over 50 years combined experience in the creation of community listening teams, community development, education, and faith-based contexts, and both qualitative and quantitative participatory program evaluation.

Mauren Okasinski, ***MSW - University of Michigan Lecturer***

Maureen Okasinski, MSW integrates academic rigor with practical, community-led practices in her consulting work. Her approach is grounded in participatory practices that center each organization's, and their associated community's, values and culture with high quality-evaluation methods. She has 20 years experience in leadership, program development, research, design and

evaluation, grant writing and management, budget management, and direct practice. This includes nine years of social work teaching, 14 years of social work practice, and six years in consulting. She earned an MSW from the University of Michigan with a major in policy and evaluation. She has taught at the University of Michigan since 2012.

Bianca Vazquez - *Founder & Director, Beloved Community Incubator (BCI)*
Bianca Vazquez is the Program Director at Beloved Community Incubator in Washington, D.C. Neighborhood listening sessions led to her engagement with small micro-business projects with local residents, which led to the founding of BCI. She believes in the power of worker-ownership to substantially transform communities and the economy. Bianca is trained in community organizing by the Industrial Areas Foundation, Faith in Action Network, and Gamaliel Network. She has lived and worked in Washington, D.C. for 10 years. She has strategically listened to thousands of people over the past decade.

Meghan Sobocienski - *Founder & Director, Grace in Action Collectives*
Meghan Sobocienski is a Founder and Director of Grace in Action Collectives in Southwest Detroit. Meghan spent five years as a Community Organizer with the PICO (Faith in Action Network), and five years working as a Co-Organizer for the Organizing for Mission Cohort (Network) through the Evangelical Lutheran Church in America (ELCA). Through this work Meghan conducted over 1,000 one to one listening conversations to develop communities of support and change strategies. Meghan has led the growth and evolution of Grace in Action Collectives through the past eight years, growing the organization from beginnings to the mid-sized organization it is today. Meghan has an MDiv. from the Lutheran Theological Seminary in Berkeley, CA, and a BSW from Capital University in Columbus, OH. She is an ordained Deacon in the Lutheran church (ELCA).

Evaluation Design

The team applied a utilization-focused approach examining processes and outcomes of the existing program gathering qualitative and quantitative data. Participatory evaluation practices manifest at each stage of the evaluation, integrating relevant organizational staff, volunteers, and Board members from planning through analysis. The evaluation methodology for assessment of the existing program relied heavily on qualitative data gathered through individual interviews and small group discussion with key interested and affected parties of the PWSRCAC's Peer Listener Program. The evaluation gathered and analyzed existing program qualitative data from training manuals, curriculum, and recordings. The evaluation employed a literature review of existing scholarly research around peer listening and similar programs, gathered qualitative data through interviews with staff at other peer listening programs nationwide, and conducted interviews with key stakeholders associated with PWSRCAC. Data collection and analysis progress was done in three stages.

Stage 1: Discovery and Planning Phase

Early engagement with project staff: This engagement provided necessary insights into organizational and community culture and values to ensure that the evaluation process was culturally relevant and responsive, to further refine the evaluation plan to meet the needs and expectations of the PWSRCAC's Board and staff, and to identify key interested and affected parties for interviews in the next two stages. During this stage, the team set communications and meeting plans with the Council's project coordinator to provide evaluation updates, problem solve as needed, and assure that the evaluation remained consistent with the organization's goals.

Literature Review: Utilizing the extensive articles database through the University of Michigan library system, the team scanned academic research published in scholarly journals focused on peer listening or similar programs that address disaster response, mental health, and community resiliency.

Scan of Existing Programs: The team identified 15 active peer listening programs from which seven were selected for an in-depth look.

Existing Program Data: Council staff provided existing program materials (the Guidebook, manual, and video link). There was no other program data available.

The results of staff engagement, literature review, and existing program data review formed the foundation for interview questions with current staff and Board members, as well as with staff from other programs.

Stage 2: Description and Comparison of Similar or Cross-Applicable Programs

Following the scan of existing peer listening programs, the team and Council staff and volunteers identified seven programs to engage in one-to-one interviews. The interview protocol and questions focused on a set of topics determined in conjunction with Council staff and volunteers that provided a comparison to the existing program and insight into revisions and development for its next iteration. The team approached interviews and relationship building with each program with an eye to sharing resources such as training manuals and to building ongoing partnership between programs so as to remain relevant and effective in their work. The team added three additional online/book length curricula to this group. The resources (e.g., training outlines and intake forms) the organizations shared and found through the literature review are in the appendices.

The literature review and scan of existing programs identified evidence-based and best practices to inform PWSRCAC's revisions and to meet the program's purpose and needs within the essential components of the PWSRCAC Peer Listening Program: building community resilience, promoting peer-to-peer support, disaster recovery, and/or empathetic listening.

Stage 3: Assessment of PWSRCAC Peer Listening Program

To assess the strengths and areas for improvement of the current Peer Listening Program, the team conducted one-to-one interviews with eight individuals and analyzed existing program materials in comparison to the literature and program reviews.

Interview protocols and questions were developed based on gained cultural knowledge, priorities set by the Council staff and volunteers, the type and quantity of existing program data, and the results of the literature review. All of the stakeholders interviewed completed consent forms.

Participatory Analysis and Reporting

Participatory analysis involved three rounds of sharing results. First, a selected set of Council staff and volunteers reviewed the annotated bibliography and active program scan. Second, the staff and volunteers reviewed the results of the program scan. Third, using a presentation slidedeck and draft report, the evaluation team shared results and recommendations with a larger body of Council volunteers and staff. Their input has been integrated in the final report.

Literature Review

Component Methodology

The literature review yielded 23 journal articles and books in the University of Michigan Library articles database relevant to the PWSRCAC Peer Listening Program evaluation. Keywords used were peer listening, peer support, peer-to-peer, community based psychological first aid, psychological first aid, and disaster mental health. Articles from 2000 and later, and specific to disaster, were given priority in selection as were those that provided information about program structure regardless of whether the peer-to-peer program was focused on responding to disaster. Articles were selected for content focused on program design and structure, virtual and in-person delivery, training provided, training manuals, legal/ethical domains of peer support programs and supervision provided, essential information on trauma, best practices, and outcomes of the programs. The annotated bibliography can be found in Appendix A.

Results

The literature review used a set of evidence-based books, manuals, and planning programs designed for disaster response by both lay people and professionals. The topics of scope, design, training, supervision, support, and evaluation of the program discussed in the literature review prove relevant to the re-design of the PWSRCAC Peer Listening Program and new avenues for a vision of what can be provided to support the community in both immediate response and longer-term recovery.

Program Design

In reviewing the program design approaches, central themes included: versatility within geography and cultural contexts, applicability to PWSRCAC's mission, and the ability to contribute to community resiliency.

> *"The impacts of a disaster like the Deepwater Horizons Oil Spill can be expected to unfold over many years, providers in affected areas should be trained not only in immediate response, but also in the provision of long-term, multisystem, culturally appropriate, and accessible services."*
>
> *- Family Resilience Following the Deepwater Horizon Oil Spill: Theory and Evidence (2021), page 44.*[21]

Approaches

The literature provided information about two particular direct support, disaster response models: Community Based Psychological First Aid (CBPFA) and Psychological First Aid (PFA). While they sound and are similar, they are designed for two different types of peer listeners.

The Community Based Psychological First Aid model is designed for members of a community without prior training, as compared to the Psychological First Aid model which is designed to teach mental health, first responders, and medical professionals skills in responding to mental health needs in a disaster. CBPFA, developed over 30 years of work in responding to natural and technological disasters in 20 different countries, is delivered in the context of peoples' social networks in the location of their choosing rather than in formal settings. Members of the community are trained to provide basic psychological support to their family, friends, neighbors, and co-workers while managing their own stress. It is used most often in the context of traumatic stress and is customized to a community's needs and culture.[2, 16]

The Psychological First Aid model operates within the framework of an authorized disaster response system and is designed for delivery by mental health and other disaster response workers who may be embedded in a variety of response units such as school crisis response teams, faith-based organizations, first responders, and primary and emergency health care. It is used in the immediate aftermath of disasters and terrorism. It is expected that mental health and other disaster response workers will deliver it in community settings such as shelters, field hospitals, crisis hotlines, and feeding locations.[3] Note that sometimes the term Psychological First Aid is meant more generally for a variety of strategies for basic psychological support including those provided by community members and mental health professionals.[16]

A third approach, Disaster Mental Health (DMH), which refers specifically to psychological support provided by mental health professionals in preparation for, response to, and recovery from disasters, was not included as this is outside of PWSRCAC's intent. The American Psychological Association established the Disaster Resource Network in 1992, each state with its own coordinating body, providing training in Disaster Mental Health.

Because of the number of Alaska Natives within the Prince William Sound region, the literature review sought peer support models designed by Indigenous community members. The Southern Plains Tribe Peer Specialist Program was designed to serve members of tribal communities through tribal organizations and communities who respond to mental illness and addiction. The peer specialists, all members of the tribal community, blend their lived experiences with formal training. While not professional counselors, they are paid staff members of said organizations. The program integrates Indigenous cultural and spiritual practices with western helping frameworks and skills. Native Americans were among the first people to employ peer support in recovery. The

peer specialists work in conjunction with professional program staff and engage in both group and individual contact with the organization's clients or attendees.[4]

Outside of these fully developed models, a group of 92 clinicians from 17 countries took part in a 3-round web-based Delphi process rating the importance of statements made about peer support programs in organizations whose employees are at high risk of exposure to potentially traumatic incidents. Among the highlights were that peer supporters are members of the community and have trust/respect of their peers, peer supporters should undergo a screening process, and that their primary role is in active listening and providing referrals for additional help when needed.[13]

Exploring the Effectiveness of In-Person and Digital Delivery Methods

While programs see success in face-to-face peer listening,[2, 3, 4, 17] evaluation of digital delivery through social media and teleconferencing with diverse identities and age groups showed virtual delivery methods had a positive impact for both those seeking peer support and those providing it.[8, 9, 11,12, 22] A preliminary review of a mental health crisis support program for veterans active in online gaming groups that was delivered through Discord (an online virtual platform) showed broad support for this method; a more extensive program evaluation is in process.[12]

Curriculum

Formal training and certification programs in mental health disaster response are provided through multiple institutions including: The Disaster Mental Health Institute at the University of South Dakota, the Institute for Disaster Mental Health (IDMH) at the State University of New York New Paltz, Denver University Graduate School of Professional Psychology (master's degree in international disaster psychology), the Red Cross, various state psychological associations, the American Counseling Association, Substance Abuse and Mental Health Services Administration (SAMHSA) Crisis Counseling Assistance and Training Program, and Veterans Affairs.[16]

> *"CBPFA provides individuals with skills they can use in coping with the stress in their own lives, as well as stress in the lives of their family, friends, neighbors, classmates, or coworkers. At the core, these skills include a knowledge of stress and extreme or overwhelming (traumatic) stress, effective active listening skills, and knowledge about how to help someone get other forms of psychological support if CBPFA proves inadequate. The CBPFA model of PFA builds on the strengths of the community in which the individual lives and provides a more systematic understanding of how to cope with difficult moments and periods in life."*
>
> *- Community-Based Psychological First Aid: A practical guide to helping individuals and communities during difficult times (2016), page 3.*[2]

The Community Based Psychological First Aid curriculum stems from the author's extensive work in natural and technological disasters and is designed to be applicable in both these types of disasters and in personal crises.

The curriculum topics are extensive, beginning with self assessment of the fit between the role and the person who is interested in providing Psychological First Aid, understanding the individual responses to stressors, the types of reactions to traumatic stress, the stress of disasters, active listening, applying problem solving skills, ways of coping with stress, providing instrumental assistance, cultural differences, understanding loss and grieving, when and how to refer people to professional services, privacy and ethical considerations, how to take care of yourself while supporting other people, and providing Community Based Psychological First Aid to children, older adults, and in rural and marginalized communities. The model presented in the text is an individual training model with an appendix describing how to develop a community-based program with a team of stakeholders who can customize the curriculum to the particulars of a community.[2]

> *"Psychological First Aid is an evidence-informed modular approach to help children, adolescents, adults and families in the immediate aftermath of disaster and terrorism. PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping."*
>
> *- Psychological First Aid, Field Operations Guide (2006), page 11.*[3]

The curriculum for Psychological First Aid includes professional behavior, guidelines for interaction, including behavior to avoid, tips on working with children, older adults, people with disabilities, preparing to enter the setting where emergency services are being provided, and noticing signs of acute stress. Core actions of Psychological First Aid are detailed: contact and engagement with the person, enhancing the person's feeling of safety and comfort, stabilization of people who are emotionally overwhelmed, information gathering about current needs and concerns, providing practical assistance, connecting people to their primary social supports, stress reactions and coping skills, and referrals for additional services when needed.[3] Developed by a 25-person group of mental health disaster specialists, the curriculum met the criteria for evidence-informed design and content.[6]

The curriculum for the peer specialists of the Southern Plains Tribe program is developed by each organization and designed unique to the state and tribal group. The core curriculum includes defining the role, work skills, active listening, and other interpersonal skills, assessing and dealing with risk, setting healthy boundaries, cultural competency, trauma and coping strategies, healing and self care, motivational interviewing, goal setting, group facilitation, health education, and addiction and recovery. Peer specialist may complete extensive formal certification (for example in Oklahoma there is a 40-hour initial certification and required continuing education).[4]

External program design and curriculum are not the only options for mental health disaster response. Disaster response designed and carried out by the affected communities of natural disasters in Asia showed immediate and long-term impacts.[7] A program to provide support to caregivers completed through co-design by the affected communities members proved successful and resulted in a self-facilitated support group by caregivers that continued for 2.5 years.[8] The success of increasing the use of positive coping in a school-based, 8-session group led by professional facilitators following an EF5 tornado in Moore, Oklahoma, demonstrated an alternative approach for responding to community mental health needs following disaster.[20] Interventions in school settings are effective for fostering resilience in youth following an adverse event.[21]

Training, Supervision, and Support for Peer Listeners

Both the Community Based Psychological First Aid and Psychological First Aid models do not describe structures or processes for providing additional training, supervision, or support to peer listeners once they have completed the initial training.[2, 3, 4] However, other research identified its need and value to both professional and lay mental health disaster responsers.[8, 9, 17]

Training for disaster mental health workers that used simulation-based education has been used for disaster preparedness training for current and future healthcare professionals. The effect of simulation-based disaster psychological support education improved the learner's positive

learning attitude, crisis management, problem-solving skills, knowledge of psychosocial support, and confidence.[11] In Korea, a team developed a Psychological First Aid mobile app named Psychological Life Support to provide disaster workers with information on disaster situations, apply Psychological First Aid techniques, and assistance in the recovery of their traumatic stress after a disaster. Used in a technological and natural disaster response simulation training, the 19 participants found this tool worked well within the simulation with participants experiencing realistic disaster situation, strong satisfaction with educational methods using a mobile application, confidence in providing disaster relief by integrating experience and knowledge of the Psychological First Aid app, and self reflection as disaster health care workers.[11]

Support to peer listeners while they are providing support to others can be done through self directed online groups[8] and by mental health professionals to active peer listeners. Professionals from the U.S., Canada, and Australia successfully used a popular social media app to provide support to frontline health care workers during the COVID pandemic in China.[9] A disaster support team that provided Psychological First Aid during Hurricane Katrina relief reported that a peer support model of debriefing with the team had a significant impact on the quality of their work and their coping skills.[17]

The international clinicians group recommended that peer supporters should not provide peer support until they have demonstrated that they can meet the standards of the training, be supervised by a mental health professional in an ongoing way, and that attention to the peer supporters' own well-being is maintained.[13]

Program Evaluation

Among the eight recommendations developed through the Delphi Technique with a group of 92 clinicians was that “peer support programs should establish clear goals that are linked to specific outcomes prior to commencement. They should be evaluated by an external, independent evaluator on a regular basis and the evaluation should include qualitative and quantitative feedback from users. Objective indicators such as absenteeism, turnover, work performance, and staff morale, while not primary goals of peer support programs, may be collected as adjunctive data as part of the evaluation.”[13]

Methods to determine the success of the program or aspects of the program used with the peer listeners were: 1) Semi-structured individual interviews for a caregiver online support group whose results showed participants found the experience of being part of a co-design group by telehealth positively enabled participants from dispersed geographical areas to take part in the co-design process, and they established group cohesion despite their differences and geographic distance from each other.[8] 2) Focus group interviews with 19 disaster health care workers from community

mental health service centers on their training to use technology app for psychological first aid training confirmed the effectiveness of the app at addressing some prior research cited limitations of simulation training.[11] 3) Surveys with participants done at the completion of the BP Deepwater Horizons Oil Spill Peer Listening training reported that the training was well organized with useful and application information.[19] 4) Evaluator used surveys with program participants the online program, Overstack, that delivered mental health crisis support through Discord.[12] Discord is an online platform in which users can create their own communities and complete multiple digital activities such as chats, video conferencing, and sharing links and resources.

Larger Questions

Community Plan for Disaster Mental Health Needs

Disaster mental health community planning assists communities to act on long-term resilience and recovery beginning with preparation, development, and implementation of a trauma-informed collaborative process that prioritizes lasting emotional wellbeing along with survivors' short-term needs.

> *"Following the 9/11 terrorist attack, FEMA asked states to completed disaster response plans, however, according to the US Department of Health and Human Services, 64% of state emergency plans did not adequately plan for emotional needs."*
>
> *- Disaster Mental Health Community Planning A Manual for Trauma-Informed Collaboration (2020), page 39.*[5]

Smaller communities can and should develop disaster mental health response plans ahead of a disaster with a collaboration of community stakeholders inclusive of community members and staff of formal institutions such as schools, businesses, and health care.[5]

Cultural Considerations

For peer listening in the Prince William Sound region, the integration of Alaska Native cultural and spiritual traditions and practices into planning and curriculum development in those communities is important.[4, 5]

Community Capacity Building Versus Individual Skills Building

The immediate success and long-term impact of community-led responses to natural disasters in Asia illuminated the potential of response and action designed within and carried out by the community and shift the role of organizations in disaster response.[7]

> *"The most important role that relief and development agencies can play in a post-disaster situation is to understand the importance of creating a space where the affected people can come together to instigate change. They need a platform where they can link up with other similarly affected groups, in order to rebuild their lives and their communities as*

soon as possible, with secure livelihoods, and where they can re-establish their rights and form new relationships within the local system."[7]

- Seeing a disaster as an opportunity – harnessing the energy of disaster survivors for change (2011), page 2.[7]

Adjacent to this approach, the U.S. government has provided support for youth leaders to develop disaster preparedness campaigns and programs within their own communities.[18]

National Peer Listening Program Scan

Component Methodology

The objective for the review of peer listening programs from across the country was to document program design, best practices, and models to adopt, as well as understand legal and ethical concerns and locate additional resources for training. Qualitative analysis of semi-structured interviews with program staff was chosen to gain these insights.

Purpose Driven Consulting researched and subsequently presented PWSRCAC with a list of 15 peer listening programs from across the country; organizations who currently operate peer listening, disaster response, and/or mental health first aid programs. The programs spanned disaster response and mental health first aid, community listening, and one on one peer listening focused on grief and life transitions, substance abuse, and school based peer to peer programs. A limitation of the initial program list is that none of the programs specifically engaged Indigenous communities. The initial list provided key program information (year founded, number of trained listeners), program delivery methods, and resources available (best practices, disaster related materials, etc.). From that list, PWSRCAC staff and volunteers selected their priority programs for interviews, and PDC pursued programs for interviews.

Topics covered in the interview questions included program recommended best practices, program design, curriculum, peer listener recruitment and supervision, program evaluation practices, and future directions for the program. Questions can be found in Appendix B. PWSRCAC program staff and volunteers reviewed the questions and made suggestions for further revisions. Interviewers used the question guide to make sure all desired topics were addressed, most interviews progressed according to the order of the question guide. Detailed interview notes were taken and then rewritten for clarity. All three evaluators conducted the interviews.

Listed below are the organizations who completed the interview. The first five were on the priority program list established by PDC and PWSRCAC. Two of those original priority programs did not respond to requests for interviews (Gillings on the Ground and the International Fire Fighters Association Peer Support Program).

1) Stephen Ministries
2) Ann Arbor MS/HS Peer to Peer program
3) Red Hook Initiative, Local Leaders Program
4) Mississippi Alabama Sea Grant Consortium
5) Vibrant Crisis Emergency Care Team
6) Nova Crisis Response Team

7) University of Michigan Counseling and Psychological Services Peer Listening Program

Purpose Driven Consulting conducted hour-long interviews with program staff, and often additional board members, from 3/2/2022 to 4/07/2022 with eight hours of total interview time. The interviewer took notes during the interview. These interviews expounded upon the different configurations that are possible for a community listening program, including a range of supervision models, community engagement practices, curriculum configurations, listening models, and training programs.

Three additional curriculums encountered through the literature review are included in these results. No interviews were conducted with staff associated with these programs and therefore, some results reported are for less than 10 programs/curriculum reviews. This is specified within each data category.

1) Community-Based Psychological First Aid by Gerard Jacobs–a full length book.
2) Psychological First Aid developed by SAMHSA and the National Child Traumatic Stress Network–field operations guide, webinar and handouts.
3) The Peer Support Toolkit from the Southern Plains Tribal Health Board.

Note: VIBRANT Crisis Response and SAMHSA's Psychological First Aid are designed specifically for trained mental health professionals and other trained disaster responders. While these are not consistent with the PWSRCAC program design, they are included because they are disaster response programs and hold relevance to the questions PWSRCAC sought to have answered.

One evaluator coded the interviews, compared responses, wrote summaries, and discussed the results. All three evaluators repeatedly read the interviews to identify overarching best practice, program approaches, clarify details of each program, and develop the analysis of approaches. The iterative process of discussing interviews and comparing programs aided the team in refining the results and developing the approach framework. A summary of the program interviews can be found in Appendix C.

Results

The results section summarizes commonalities and trends in program design, delivery, and evaluation. Grouping like programs, the evaluation team synthesized these into three approaches for peer listening programs.

Programs Surveyed

The programs reviewed span the United States. Three programs are implemented across the country through sponsoring churches and national organizations, two are based in Michigan and

sponsored by the University of Michigan. Two are located in New York, one in Mississippi-Alabama, and one in Oklahoma. These four are sponsored by nonprofits.

Program Scope

The population served fell into three categories 1) a geographic boundary, 2) a specific population (e.g., college students, residents of a specific neighborhood) within an institutional boundary, or 3) anyone affected by the disaster. The focus of their program was defined by their mission.

Table 1: Age Demographics

Age of Population Served	#
All ages	5
Students (college students, middle, high school)	2
Adults	3
n=10	

The field spanned crisis and disaster response and mental health/general well-being. Most programs selected for review were disaster response. Of the four that had another primary focus, these were selected because of mental health and wellness focus that is fundamental in a disaster peer listening program. Programs varied in the focus of why they provided service.

Crisis and Disaster Response - For communities and individuals who are experiencing trauma in the aftermath of disasters or traumatic events. This includes instances of mass violence, natural disasters, and technical disasters. The goal here is to identify people who need more mental health intervention, explain typical responses to traumatic events, and work directly with community members. Some programs train listeners to engage on the longer-term impact of disasters.

Mental Health and Well-Being - Peer listeners are trained to listen and understand challenges present in someone's life. Peer listeners are trained to support in a variety of areas: loneliness, addiction, adjustment/transition, managing stress, grief, divorce, amongst others. The primary role of listeners is to listen, support, provide guidance with resources and mental health referrals.

Table 2: Conditions Program Addresses

Program Focus	#
Immediate disaster response	3
Ongoing disaster response	3
Mental health and well-being	4
n=10	

Program Design

Who are the Peer Listeners?

Each program referred to the person listening and the person being listened to with different terminology. For the purposes of consistency in the report, we utilized the terms peer listener and care receiver.

The demographics of who is eligible to be peer listeners varied based on the sponsoring organization, the conditions being responded to, and the mission of the organization. All of the programs had connections with or access to mental health workers who were available to provide support and take referrals from peer listeners. Additional distinctions existed between the structure of supervision, credential of trainers, and additional training opportunities.

Table 3: Eligibility to be a Peer Listener

Peer Listener Eligibility	#
Community leaders	3
General population	2
Students	2
Mental Health/disaster response professionals	2
Church members	1
n=10	

Who Do They listen To?

All disaster response programs made anyone affected by a disaster an eligible participant.

Table 4: Population of Care Receivers

Care Receiver	#
General population	7
Students	2
Mental health/addiction service recipients	1
n=10	

How are Peer Listeners Supervised and/or Supported?

The supervisors/trainers in six programs held a mental health or social work degree, two programs did not specify the credentials of the trainer. The exception was Stephen Ministries, which provided a distinct 40-hour training for supervisors. None of the programs we interviewed had train-the-trainer tracks that were available as a first step in participating in the peer listener program. Four programs had ongoing training available. The two programs with the most ongoing support were Stephen Ministries and UMICH CAPS Program who required regular ongoing training and supervision.

Table 5: Credentials, Supervision, Support

Trainer/Supervisor	#
Counseling/mental health-related degree for supervisor or trainer	6
Specified training to supervise (degree not required)	2
Additional training beyond initial	4
Supervision or self directed ongoing support	4
n=8	

Many of the disaster/crisis response related programs, by nature of the program and design, had short-term interactions between peer listeners and care receivers. With programs focused on mental health and general well-being, the one on one relationship was often extended (up to one

year). The corollary is that programs that had extended relationships between listeners and care receivers had the most formal supervision structures.

A best practice across both types of programs was to engage listeners as a team or cohort and to cultivate relationships between listeners.

Differences in Program Design Based on Program Approach

What emerged in analysis were distinctions in program approach as seen in the scope of the program (who the program serves and the issue being addressed), its design (how peer listeners are trained, supervised, and supported) and some differences in their recommended best practices and training curricula. There are three main types of disaster response programs: community rooted peer listening programs, immediate crisis response/initial disaster response programs, and a hybrid model of sustainable, resilient communities that are prepared to respond to disaster through immediate response and ongoing, trained community listeners. Some of the organizations reviewed engage in only one of these three types of disaster response, some engage in two, and some engage in the hybrid of both.

Community-Anchored Ongoing Peer Listening/Group A is about whether listening is intended to be ongoing, community anchored, and impact social cohesion and well-being.

Short-term, Initial Disaster Response/Group B listening is intended as a short-term, initial disaster response that provides immediate opportunities for processing the impacts of the disaster and crisis mental health referrals.

Hybrid Model of Resilient Communities/Group C utilizes ongoing trained community listeners for resilient communities, where listeners are prepared for and able to be mobilized in a disaster, understand the ongoing long-term effects of disasters, and utilize the skills regularly.

Within each group there are variations based on the individual organization's mission. Further analysis of these emerging typologies are outside the scope of this evaluation report. The overview of these provides a frame for PWSRCAC to aid in considering the scope and design of their program based on their mission and their stakeholders' shared values and vision for the program.

Table 6: Emerging Typology for Peer Listening Program Approach

Group A/Ongoing	Group B/Short-Term, Initial Response	Group C/Community Resiliency
Scope: ongoing support for mental health and well-being	Scope: immediate disaster response	Scope: immediate and long-term support disaster response
Peer listeners are community members within the community being served	Peer listeners are community members or leaders, mental health professionals, or disaster first responders	Peer listeners are community members or local leaders
Peer listening occurs within mental health/counseling programs (2 of 3) or within social network (1 of 3)	Peer listening occurs in disaster responses center immediately following a disaster (4 of 5) and within the social networks of the peer listener (1 of 5)	Peer listening occurs within the social networks of the peer listener
Initial training Ongoing training and support	Initial training No ongoing supervision or support (excepting NOVA with advanced training)	Initial training
Example programs: ♦ Stephen Ministries ♦ Peer listening Program in Counseling and Psychological Services at the University of Michigan ♦ Plains Tribes Peer Support program	Example programs: ♦ Mississippi-Alabama Sea Grant Consortium Peer Listening Program ♦ NOVA Crisis Response Team Training™ Program ♦ Crisis Emotional Care Team ♦ Disaster First Aid (SAMHSA)	Example programs: ♦ Red Hook Initiative, Local Leaders Program ♦ Community Based Disaster First Aid, Gerard Jacobs

Best practices:	Best practices:	Best practices:
⧫ Highly structured training ⧫ Structured ongoing supervision ⧫ Usually have a contained geographic region or serves a specific group (college, university) ⧫ Usually a structured way to request a listener ⧫ The relationship is time bound, ongoing training opportunities ⧫ Group supervision with a trained professional regularly	⧫ Higher average training times ⧫ Supervisors are mental health professionals ⧫ Part of the training is about impact of disasters and common responses to disaster ⧫ On average 58% role play in trainings vs didactic training ⧫ Cultivate a network of listeners ⧫ Good training and pathways for mental health referrals	⧫ Training on accompanying people in crisis and long-term impacts of disaster on a community ⧫ Trauma informed ⧫ Supervision by mental health professional or social worker ⧫ Representative diversity of peer listeners ⧫ Some other touch point to the community as opposed to just disaster training ⧫ See peer listening as a key component to creating healthy and resilient communities

Hours of Initial Training

The average across all groups was 17 hours-excluding one outlier. Group B has the widest range of initial training hours. The smallest number of initial training time was Mississippi-Alabama Sea Grant which required four hours of training and the longest was NOVA Crisis Response that offered 24 hours of initial training and 24 hours of advanced training. Groups B and C were most similar in the scope of their program-responding to disasters.

Commonalities between the most structured programs included a significant amount of initial training for listeners; the average across all programs was 15 hours. The average for programs that equip leaders for disaster response is 19. Where advanced training components or train-the-trainer programs existed, they were distinct training tracks, with additional training hours required.

Table 7: Initial Training Time

Topic	Average hours
Group A/Ongoing	14.5
Group B/Short-Term, Initial Response	14
Group C/Community Resiliency	20
n=8	

Method of Delivery for Training

Previous to the COVID-19 pandemic, 100% of programs completed training in person. Currently, 100% of the programs interviewed shifted their program delivery to virtual due to the pandemic. Five of six programs were exploring continuing their program through virtual or hybrid instruction. Their main reasons for doing so were expanding access to the training and cost reduction. One program only provided online training and two did not specify how training was provided.

Curriculum Topics

Asked about what topics their curriculum addressed, those with the largest frequency were active listening, identifying mental health concerns, maintaining boundaries, making mental health referrals, and common responses to trauma. The curriculums prescribed how to interact with care receivers and how to close out a receiver relationship (whether it was one session or a year-long interaction). Other topics for training identified with less frequency were: depression, confidentiality, anxiety, grief, bystander intervention, individual and community disaster plans, and multicultural considerations.

The data for this section came from both interview responses and from the agendas and curriculum that the interviewed organizations shared. Those resources were Red Hook-3 years of curricula, MS Sea Grant-training video and manual, UM CAPS Peer Counseling training outline for pilot year, NOVA CRT-basic and advanced curriculum agenda, training themes and objectives, brochure and FAQ, Stephen Ministries-curriculum agenda and FAQs, UM Peer-to-Peer Mentor Manual, Psychological First Aid Field Operations Manual, Peer Counseling Handbook for the Southern Plains Tribes, and Community Based Psychological First Aid. Vibrant did not have a curriculum or topic agenda to share and is not included in the frequency table. Training topics represent both initial and ongoing or advanced training, if the program had the latter two. The Psychological First Aid Field Operations Manual and the Community Based Psychological First Aid

book are both designed specifically for disaster response and well aligned with the PWSRCAC Peer Listener Training Program's scope and design. The Peer Support Toolkit from the South Plains Tribes was the only peer listening program found in the discovery phase that specifically addressed Native or Indigenous peoples.

Of the programs with more extensive training curriculums (10+ hours), common training modules were multicultural considerations, accompanying people in crisis, trauma, and depression, as well as recognizing mental health crises and an action plan for making mental health referrals.

Table 8: Highest Frequency Curriculum Topics

Topic	#
Maintaining healthy boundaries	7
Recognizing mental health crisis	7
Active listening	7
Providing peer listening to people in crisis	6
Common responses to trauma	6
Alcohol/addiction	6
Multi-cultural considerations	5
Grief	5
Confidentiality	5
Suicide	5
Depression	5
n=10	

Balance of Training/Role Play

Most programs had a split between training and role play that averaged 40% role play and 60% presentations. More than 50% of programs named that a growing curriculum edge was to add more opportunities for role play (n=7).

Program Evaluation
Evaluation practices varied widely, with the consistent theme being a need across programs to engage in more data collection and evaluation. Programs tracked the number of people trained, when and where training occurred and training topics. Few had outcome data.

Program Identified Best Practices

In the interviews, each program staff was asked to identify their best practices. Their recommendations came from their years of experience, their identification of their success and areas in which they have identified growth and change are required in the program to further their mission. The three curriculum only/no interview programs that include some information consistent with the verbally identified best practices are included in this summary. This in-depth review illuminates the strengths and best practices of peer listening programs across the country. In Appendix C, we provide a summary of each program's highlights, program scope, curriculum, training program, and best practices. In the appendices, we included resources shared by each program, such as agendas, news articles, or impact reports, as well as a short analysis with considerations for adopting and adapting each program. Combined, these can serve as a resource and a guide around key choice points as PWSRCAC revamps its program.

The baseline starting point for many of these programs is that peer listening is a necessity. The combination and compounding of increasing natural and technical disasters, mental health service providers being at or near capacity, and isolation is decreasing the ability of communities to bounce back or come back to a new normal after new instances. Peer listening can increase social connections, decrease feelings of isolation, and respond to feelings of mistrust and uncertainty because it builds from established social networks.

The following best practices were identified in 4 or more programs.

- *Formalized Process and Structure:* Goals and target audience of the peer listening program were decided. The goals formulated for the program informed peer listener selection, training, supervision, and follow up.
- *Active and Cooperative Learning:* People zoned out when listening to didactic content. For training to be effective, people need to be active, need to connect to things with which they are familiar. Small group interactions and role plays give greater comfort, more space for questions and deeper reflection. Multiple programs named the goal of 40-50% of interactive content.
- *Create and Cultivate a Cohort Based Model:* A cohort model indicates that peer listeners are networked with one another in some way (regular group supervision, online community, regular ongoing training) and are encouraged to build relationships with one another. A cohort model enables more successful delivery of the support network and supervision that peer listeners require. Peer listeners will have their own mental health needs to be

attended to along with their interest in supporting others. A cohort model was shared to increase the peer listener's own sense of social connectedness and increase longevity in the program.

- *Knowing When to Refer and Having a Referral Plan:* Peer listeners across a variety of programs received training on how to identify mental health crises and received clear instructions of how to escalate a need to a mental health professional.
- *Trauma Informed:* Curriculums were revised in recent years to include trauma, common responses to trauma, awareness of adverse childhood experiences, and the role of community listening with precautions not to retraumatize people.

The following best practices were identified in 3 or more programs.

- *Supervision of Listeners:* Supervision must exist and be regular and consistent. This enables healthy boundaries. Supervision is done with a small group of peer listeners who meet for peer group accountability. Oftentimes this happens in a group setting with peers.
- *Formal Request to be Connected with a Listener:* The program is structured so that a potential care receiver has to put in a formal request (either online or with a supervisor) to begin their peer listener relationship.

The following best practices appeared in two programs and match PWSRCAC goals.

- *Representative Diversity of Peer Listeners:* Having diversity of peer listeners including gender, identity, and language spoken may increase the number of people being listened to from these communities and increase mental health referrals for people that come from marginalized identities.
- *Listeners Must Utilize the Tools Before Becoming a Trainer:* Trainers are selected from participants who have completed basic training, have utilized the skills, and demonstrate an interest or ability in facilitation and training.

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Stakeholders’ Program Assessment

Component Methodology

The objective for stakeholder interviews was to describe the successes, challenges, and satisfaction with the prior Peer Listening Program, unique needs of the Prince William Sound region, content and focus of the future program, and resources or support available to the program.

Qualitative analysis of semi-structured interviews with key individuals associated with PWSRCAC was chosen because this method facilitates insight that can be used to understand complex and contextual elements. It is important to note that these were open ended questions and thus the discussion of topics, concerns, and ideas about the future program is exploratory rather than a sound ranking of what is most important (that will require a different methodology). Purposeful sampling was used to identify key individuals for interviews. Interviews were conducted between April and May 2022. Council staff selected the key individuals who were chosen for their connection to the PWSRCAC, especially those considered to have relevant insights.

The semi-structured interview questions were developed to respond to the learning sought as identified by the PWSRCAC. Council staff and volunteers reviewed the questions and made suggestions for further revisions in keeping with those priorities for these interviews. Interviewers used the question guide to make sure all desired issues were explored but did not always use exact wording or the predetermined order of the questions. Respondents were encouraged to elaborate and share stories of their experience for which direct quotes were written down when possible. Detailed interview notes on key issues identified by participants were taken and then rewritten for clarity. Two evaluators conducted the interviews. All three evaluators repeatedly read the interviews to discuss and identify themes. Two evaluators coded the interviews, compared responses, wrote summaries, and discussed the results. This iterative process of coding, writing, discussion, and rewriting summaries of the themes helped evaluators to interpret and refine the results.

Results

Eight interviews were conducted; seven via Zoom and one on the phone (8.10 hours). Most were Board/former Board members or staff. One identified as an Alaska Native. The majority of interviews were PWSRCAC affiliated and thus provided an institutional scan of the issues, concerns, and insight into essential program components. Most interviewees attended prior Peer Listener training and half had used the skills. Demographics for participants are shown in tables 9 and 10. Regardless of experience with the Peer Listener Program, the interviewee's knowledge of the

effects of technological disaster and their care for the community are evidenced in their words, which are amplified in this section of the report.

Table 9: Stakeholder Demographics-Relationship to PWSRCAC

Role	#
PWSRCAC Board member/former PWSRCAC	4
PWSRCAC staff	2
Other professionals	2
n=8	

Table 10: Stakeholder Demographics-Experience with PWSRCAC Peer Listening Program

Connection to the Peer Listening Program	#
Attended a Peer Listener training	5
Reported use of skills from training	4
Other mental health training/educational background	3
n=8	

Unique Needs of the Prince William Sound/Exxon Valdez Oil Spill Region

> *"This region is really unique – all of the communities are far apart in distance and general location. There just are not roads between a lot of these locations. The distance is not just miles. There are also huge differences in cultures and use of the lands."*
>
> *–Stakeholder Interview 1*

Frequently cited by the interviewees as factors in understanding the unique needs of the region were the physical spaces, the distance between communities, and the size of each community. This was paired with their acknowledgment of the cultural and occupational diversity within and between communities that includes 19 different Alaska Native communities, fishing and tourism industry differences. The needs are complex and interviewees often described the nuances of these, from fears that the Native communities would feel abandoned in another technological

disaster to the kinds of conflict that occurred because of the significant financial gains of some residents, the compensation for losses based in details of industry, and of seeking approval from elders for who one could talk to about their concerns. One person summed up the complexity with the straightforward need to address "how not to hate your neighbor." Of particular relevance to considerations for revisions to the Peer Listener Program, two people talked about the transience of mental health professionals within the community, a fact that makes it hard to build trust for help seeking and to embed disaster mental health response within the professional helping community.

> *"The main limitation of the program for us is the attrition of mental health workers in small towns. Our main problem in executing this program, and really any program, is staff attrition. It's cyclical, and staff leaves. They cycle in and cycle out of small towns."*
>
> *–Stakeholder Interview 8*

Concerns To Address in the Revised PWSRCAC Program

> *"There is a large stigma around counseling. If you can train people in the community that can recognize the signs of someone in distress and find them the support they need, it can break down the sigma and be very effective and helpful."*
>
> *–Stakeholder Interview 4*

Interviewees cited that people are not aware that they or someone else would benefit from mental health services, as well as the discomfort or stigma associated with seeking them. One person described that they were told by their legal advisors "not to talk" about what was going on. While interviews described generally the need for culturally relevant responses, only two had a specific example of this.

Five of the eight interviewees expressed concern over the lack of resources allotted for mental health services. There was a sense that while there was and is a great, ongoing need for mental health support, the people and monetary resources available did not match the mental health needs that existed. Ideas for how this might be addressed were posited by stakeholder discussed in the next section.

> *"Mental health is super important and overall is under-resourced. PWSRCAC could have a LARGE role in this in our community, especially thinking about preparing for another disaster."*
>
> *–Stakeholder Interview 1*

Table 11: Stakeholder Identified Areas of Concern

Stakeholder Concerns	#
Specified technological disaster unique effect	6
Uniqueness of each community/disparities between communities (income, access, size)	5
Need for adequate resources to respond to mental health and wellness	5
Culturally responsive and relevant	4
Help seeking stigma	4
Lack of mental health resources/retention of staff	2

Support for the Program

> *"One of the biggest things I learned was how to be a listener."*
>
> *–Stakeholder Interview 6*

Prior experience with the Peer Listener Training Program

Five of the eight people reported attending a Peer Listener training. The difference between technological and natural disasters, stigmas around seeking mental health support, and the value of being a listener were the topics covered in the training that were most often identified. Three members described with details specific positive memories of their training attendance.

> *"I got to know people who I had seen in meetings but never got to see in person. The people who facilitated the training were engaging and didn't just make people listen to a powerpoint but did engaging work."*
>
> *–Stakeholder Interview 3*

Four said they had used skills from the training in their social network. They described being in the role of a listener and using empathy when talking to distraught family or friends.

> *"Why I like this program in a town like ours: it gives increased knowledge of mental health, it reminds people that it's not a personal problem. When community tragedies happen that rock the foundation of a community, people get unwell and don't reach out to mental health workers. They're more likely to reach out to their peers, their friends, and families."*

–Stakeholder Interview 8

While there was familiarity with the PWSRCAC's Peer Listener Program and support for this type of program, a subset of stakeholders shared information that indicated they were not well-versed in the program, how it would respond to community needs, or had not seen a positive impact from the program. For example, one interviewee, who was well-informed about the significant harm community members experienced and the associated complex needs, stated they had been affiliated with the PWSRCAC for several years and had heard reports about the program, yet remained uncertain as to what the program did. Another said they had seen no positive effect from the Peer Listening Program.

Valuation of the Program

> *"It matters because we don't want people to forget the mistakes of our generation. Complacency can come in again if you forget everything that's happened. We need the young people to care. "*
>
> *–Stakeholder Interview 5*

All interviewed stakeholders expressed strong personal support for the program as a valuable asset to meeting community needs. There was more variation in the perspective on community support for the program. Two interviewees cited concerns about the amount of time since the Exxon Valdez disaster and how this might decrease the feeling of importance that older members of the community attached to monitoring practices and preparedness for disaster response. In this case, community education about the harm to the community from the Exxon spill responds in part to the concerns about the need to keep the community aware of risks and harm. Interviewees see this program as the first of its kind and that its existence and dissemination matter in the larger global context of technical disasters.

> *"We developed and spearheaded our own program post-Valdez and then the group in the Gulf of Mexico have used our program. I would hope that we [PWSRCAC] have a larger role in reaching out to the community and building this program up again. And we can build on that trust if there was another event."*
>
> *–Stakeholder Interview 1*

Essential for Next Program Iteration

Interviewees had much to say about what the next iteration of the program needed to be successful in regard to scope, design, and training content.

> *"My dream is [that] we do this training in fire departments, sociology programs, legal programs, and with mental health professionals. The people I dealt with when I was listening – they were bartenders, net menders, store owners, grocery clerks – your neighbors in the street… Each student should go through this program - each will grow*

up to a profession and we do need to help them develop these skills. I think it's important to train people before they're adults. We also need to train religious leaders. It's broad and the curriculum we have can be applicable to everyone, it's simple."

–Stakeholder Interview 7

Scope

Unlike support for and awareness of the need for a peer listening program, there was no one consistent answer regarding the scope of program. Immediate disaster response, ongoing disaster response, and supporting community resiliency, as well as historic trauma were all identified as significant by various stakeholders. Interviewee responses converged around the needs for the program to respond to the complexity of trauma and the diversity within the different communities, as described earlier. Some were specific in identifying preparedness and resiliency as valuable to the scope of the program.

"I've thought a lot about how these disasters like the one we had in Valdez have the ability to divide a community. I think trainings like these reweave communities together and get people to work together instead of against each other."

–Stakeholder Interview 4

Consensus around preparedness echoed in several respondents. If the program was consistently active in building a network of effective peer listeners, when a community crisis or disaster strikes, the Prince William Sound communities will become more resilient.

"We can't prevent trauma from happening – especially when we talk about man-made or natural disasters. Inevitably trauma is going to happen. What we can control is how we respond to it in order to minimize the impacts over a long time. Once you're in that cycle of trauma you have to move through that and help people move through that. The more support they have the more likely they are to move through a more normalized place."

–Stakeholder Interview 2

Design

"We need people anchored to the community to be the ones getting trained, they have to show they're going to be here. Suicide and other deaths of despair are very common in Alaska."

–Stakeholder Interview 8

While there was no one single response about who should attend training, the interviewees had a clear desire for a large group of community members to attend training so that their skills could be activated in a crisis as well as used in ongoing community care. Two interviewees described a goal of training all the PWSRCAC Board and staff, and others stated that they could link with each community through Board members, first responders, faith, and nonprofit institutions.

"We have been promoting counseling centers to take the training on, but without resources to do so. We could go beyond that - we could embed the training into some of the churches and congregations, the Native tribes, or the whole city or community spaces. The churches and community could work together to promote and put on these training and programs."

–Stakeholder Interview 4

Some people raised the question of who holds the training, whether it is PWSRCAC solely or whether it might be better addressed in collaboration and partnership. Differences of opinion existed between stakeholders about resources available within any single organization (PWSRCAC or others). One interviewee wanted to see a counseling center hold or be a key partner in delivering training. Another said that they knew the counseling centers did not have capacity to add programming with their current resources. Two other interviewees listed a larger group of local entities including churches, schools, and Alaska Native communities that could be a part of ongoing collaborative efforts–a shift that would address multiple needs for the program.

Of note in regards to scope, two interviewees seemed to have the view that the training was to be used in professional application rather than in a social context. They both stated that they had used the skills within their social network but, in other parts of the interview, seemed dissatisfied with this application of the skills. This dissatisfaction may speak to a lack of clarity in program purpose. This clarity could be addressed by revisions to the program approach and design and/or frequency of training offering that can reinforce the application of peer listening in social networks.

Frequency of Training

The stakeholder group wants a large, well-trained, connected network, increased frequency of training (at least yearly), and ongoing follow up with attendees to practice skills and learn new information. Two interviewees' response to the question about their experience with attending the training articulated well two reasons for increasing frequency and follow up.

"It's been so long I can't recall the specifics of the training at all."

–Stakeholder Interview 2

"I didn't really remember all of the things that I learned in the training because we learned them so fast…I don't really remember but I want to remember."

–Stakeholder Interview 3

Another person asked for a community-led design process. This choice would contribute effectively to expanding the number and diversity of the network of listeners, and to distinguishing the role of the peer listener from the role of the helping professional.

"I would ask the community how to set it up in its own community... and what content is taught and how it's culturally competent to that community to design the training locally and then have local sign ups...I would see a team of trained professionals working alongside community listeners in communities and from communities. Particularly this is important in Native communities. It needs to be introduced by a Native elder. Who messages it and designs it matters."

–Stakeholder Interview 6

Table 12: Program Design

How to respond to needs	#
Be a consistent presence with regular training and follow up	6
Be well-networked	5
Large group of trained peer listeners	5

The interviews included specific content and style for the training curriculum. In recalling their participation at the training, one person described how relationships are built through participation in the program. Others described the needs for practicing skills as experienced through cooperative and active learning.

"The successes: The training was so much fun. We took a big group picture on the steps afterwards. There were a lot of people there who I hadn't spent a lot of time with so I got to know people who I had seen in meetings but never got to see in person. "

–Stakeholder Interview 3

A community and culturally responsive program must account for the diversity of who is affected and how they are affected within the training curriculum as well as in the program design.

"Figuring out how to work with many different cultures because we have so many different kinds of people dispersed among so many different places. Fishing, tourism, Native cultures."

–Stakeholder Interview 6

The lessons learned from first responders and disaster here and elsewhere that a program needs to acknowledge and respond to the needs of the caregivers.

"All of us who were living here were impacted. Every single person from every single walk of life. Even the mental health workers were impacted, and we couldn't import people fast enough."

–Stakeholder Interview 7

Table 13: Training Content

How to Respond to Needs	#
Culturally relevant and competent	3
Supporting others while experiencing your own trauma	3
Trauma informed (awareness of immediate, ongoing, historic)	3
Listening skills	3
Understanding mental health/referring to professionals	3

Strengths and Areas for Improvement in PWSRCAC's Peer Listener Program

This section begins with a review of the PWSRCAC's program, similar to what the evaluation team completed with the other programs that participated in interviews and program materials sharing. Following this summary, the PWSRCAC program's design and curriculum is assessed in comparison to literature review results and the other peer listening program.

PWSRCAC's Peer Listening Program

The Peer Listener Training Program was designed to train local residents to provide peer support within disaster-impacted communities and established 10 years after the Exxon Valdez oil spill. The lay listener acts as an advisor, friend, and referral agent for individuals within a community who may not desire to seek professional services or may not know that help is available. The original Peer Listener Training Manual (created 1999, updated 2004, 2021) was developed in consultation with Dr. J. Steven Picou, a leading researcher in the field of disasters and mental health who studied both the Exxon Valdez and BP Deepwater Horizon oil spills.

Highlights

Year Founded	# of Listeners Trained	Hours of Training	# of People Served in Year
1999	24 in 2016 Unknown for 2008, 2001, 1996	14 hours: as defined in the manual 2.3 hours: video on Facebook in 9 parts Ongoing: N/A	Data not tracked

Best Practices as Recommended by the Organization

PWSRCAC's best practices are pulled from its own manual. Without program data, it is unclear to what extent these were aspirational or actual in implementation.

- *Qualified trainers* – Peer Listener Training should be conducted by qualified, local mental health professionals

- *Uplift local leaders* – Peer listeners should be individuals within a community who are highly trusted, dependable, and discreet resident volunteers. They should be representative of all cultural, ethnic, and age groups within the impacted community.
- *Formal & structured program* – During an event, the community may want to consider designating a coordinator to create a structured approach, develop a network, and ensure training takes place.
- *Supervision* – Community leaders should continually follow up with peer listeners to receive feedback and provide additional training and referral organizations when needed. Original training even provided a feedback form to be filled out after every peer listener touch point to discuss in supervision and use for program evaluation.

Program Scope

The goal of a Peer Listener Training Program is to teach active listening to create important links for the healing process after a disaster. While intended to support recovery from the long-term effects of a disaster, this network can remain in the community as an ongoing resource, as long as the community sees a need for it and is committed to supporting it. This could allow the network to be in place and available should future disasters impact the community.

Program Design

In the years since the disaster, it has been difficult to retain the energy around the Peer Listener Training Program. According to Council staff, the training was delivered at least four times since 1996. The training manual was revised at least twice, and the training video updated five times. In 2016, PWSRCAC moved from training listeners directly to a train-the-trainer model. Their expectation was that those trainers would continue to conduct peer listener training in local communities across the Prince William Sound region.

The Peer Listeners

PWSRCAC's program trains community members which can include community leaders, first responders, and mental health professionals. PWSRCAC has worked with community institutions to offer training to their leaders. One collaboration was training workers at the local counseling center in Valdez and teachers at local schools.

The current set up requires that PWSRCAC trained trainers create, implement, and maintain their own Peer Listener Training Program. As reported by Council staff, there is not a centralized process led by PWSRCAC and no supervision of trainers or listeners. As a result, PWSRCAC does not have data on who or how many people those trainers may have trained.

The original program named a best practice and expectation of supervision and coordination of listeners. It is unclear from program data how the planned program differed from the actual in this regard.

Curriculum

The 2016 update resulted in a curriculum that is upwards of 90% didactic learning. It covers the topics of effects of technical disasters, active listening, depression, coping with anger, substance abuse, signs of abuse, suicide, recognizing mental health crisis, and how to engage referrals.

Program Data

In 2016, 24 people attended a train-the-trainer session in Anchorage. An evaluator completed pre and post test knowledge and a post session. The program did not have data on who and how many people were training from prior training. The program does not have data on participants' application of listening skills following training or the number of people with whom they talked.

Assessment of PWSRCAC's Program

Of all of the programs that focused on disaster-oriented community listening, PWSRCAC's distinguishing strength is the curriculum's focus on the particular long-term impacts of technical disasters. Dr. J. Steven Picou offered an important frame of the impact of technical disasters in comparison to natural disasters, and how the aftermath can create therapeutic or corrosive communities. This clarity is a significant contribution to the field of disaster related listening. What PWSRCAC has learned about the impacts of technical disasters and recommendations on how to respond is unique and important to share. When interviewing the Mississippi-Alabama Sea Grant Consortium, knowing these distinctions allowed them to more effectively understand what was happening in their communities as well as shape their response.

PWSRCAC's Peer Listener Program, as described in the training manual, fits most closely with the Group C/Community Resiliency, providing long-term disaster response.

In comparing PWSRCAC's program scope, design, and execution to other programs, notable departures in the pedagogy and best practices were evident.

Program Scope and Design

In regard to scope, all of the disaster response programs responded to both technological and natural disasters. PWSRCAC stood out as only responding to technological disasters. The program directly developed from PWSRCAC's own program, Mississippi-Alabama Sea Grant, provides their

training in natural disaster areas. Two programs and several literature review articles were peer listening programs that occurred in other areas of mental health, high-risk for trauma, or other well-being scenarios. An important distinction is whether listening is intended to be short-term and disaster response related or longer-term, community anchored, and meant to impact social cohesion and general well-being.

For all programs, the initial training was for peer listeners, not a train-the-trainer model as in the most recent design for PWSRCAC. The initial training for peer listening programs, with the exception of one program, averaged 17.4 hours, whereas the PWSRCAC training was 14 hours. Note that the training video posted on Facebook is approximately two hours and some viewers may interpret this posting as PWSRCAC's training program because the language on Facebook does not state otherwise. Three programs provide additional training either labeled advanced peer listening or as trainer/supervisor's training.

The stand-alone train-the-trainer model, especially without significant oversight, is a departure from best practices. People expressed in stakeholder interviews that they found the training helpful, but they did not know how to utilize the tools, how to listen in a structured way, and felt as though the expectation was that they created their own individual peer listener program.

Results of the literature review emphasize the importance of ongoing support and supervision for peer listeners which can be provided through self-directed communities or more formal means led by trained or mental health professionals. This was particularly highlighted in the literature as important because peer listeners are of the community and themselves experience trauma and needs for support in addition to the support that is needed to cope with listening to the struggles of others. PWSRCAC had not implemented this.

All of the other peer listener programs are annual programs in which listeners are trained and the expectation post training is to participate as a peer listener. PWSRCAC stands alone in offering only a train-the-trainer program.

Supervisors and trainers most often have mental health or counseling credentials or, as in the case of Mississippi-Alabama Sea Grant, the organization partners with local mental health providers for the relevant sections of the training.

Program Scope and Design: Compared to Mississippi-Alabama Sea Grant Consortium

Because the genesis of the Mississippi-Alabama Sea Grant Consortium came directly from the original PWSRCAC curriculum, we wanted to focus on the similarities and departures from the original program. Similar to PWSRCAC, the need for a peer listener program came in the aftermath of a community suicide of an effected worker in an industry decimated by the technical disaster.

Both programs were imagined with the intention to relieve overwhelmed mental health workers in the direct aftermath of a disaster.

In contrast to PWSRCAC, the Mississippi-Alabama Sea Grant Consortium program fits the most closely with initial short-term, initial response, or Group B. In these programs, listening is intended as a short-term, initial disaster response that provides immediate opportunities for processing the impacts of the disaster and crisis mental health referrals.

Mississippi-Alabama Sea Grant Consortium made program designed choices and organized resources in alignment with this. They do not intend to maintain the program between disasters. The training was staffed by mental health professionals, recruited participants through mental health professional networks, and was meant to equip participants to listen to people in their social networks and scan for mental health crises. This program also had the shortest number of training hours, commensurate with their stated goals. Additionally, there is no expectation of being in relationship with or follow up from Mississippi-Alabama Sea Grant Consortium after the training. There is no ongoing evaluation of peer listeners and their skills.

When asked about the growing edge for the program, MS-AL Sea Grant staff shared the desire for more resources and investment in these community-based disaster response networks, as well as the need to supervise peer listeners and cultivate a cohort amongst them.

> *"This [Peer listening] is an important topic that doesn't get the attention that it does need. [With] All the issues across our country, whether it's a technical disaster, natural disaster, uncertainty and mistrust, we need to build networks of listeners and it's going to become more and more essential."*
>
> *–MS-AL Sea Grant Staff 1*
>
> *"[We need to have] that basis of a small group or cohort that are committed to helping to work on this kind of a topic. As one person, I can't do this by myself. One person could go to a training but it's really a group endeavor, you need a cohort. You need to have someone else you can share with - the peer listeners need that support network and supervision. Especially if they're going to be serious about it. We can't expect to send them out into the world if they're going to take this seriously. They need support."*
>
> *–MS-AL Sea Grant Staff 2*

Program Curriculum

Below is summarized the training topics most frequently occurring in other programs that PWSRCAC includes and does not include. Topics emphasized by stakeholders are bolded. Training

topics that appeared three or more times in the active program reviews and in the literature are listed. Those that are bolded were noted as important by three or more PWSRCAC stakeholders.

Table 14: Training Topic Comparison

Training topics that 3 or more other programs have that PWSRCAC did NOT have	Training topics that PWSRCAC had that 3 or more programs also have
Maintaining healthy boundaries	Depression
Trauma & common responses to trauma	Alcohol & substance abuse
Trauma informed (awareness of immediate, ongoing, historic)	**Recognizing mental health crisis & referrals**
Multicultural considerations	Referring mental health crisis
Spiritual perspectives that impact listening	**Impact of disaster on communities**
Grief & loss	Confidentiality
	Active listening
	Suicide
	Peer listening with people in crisis

Best Practices

Below are the best practices as described in the PWSRCAC's Peer Listener Program Manual that most frequently occur in other programs and described in the literature review that PWSRCAC includes and does not include. Topics emphasized by stakeholders are bolded.

Table 15: Best Practices Comparison

Best practices that 3 or more other programs/literature review have that PWSRCAC did NOT have	Best practices that PWSRCAC had that 3 or more programs also have
Trauma informed	Representative diversity of peer listeners
Regular & consistent supervision	Knowing how and when to do mental health referrals

Supervision with a trained mental health or other credentialed professional	**Cultivating a network / cohort of listeners**
Group supervision with peers	
Formalized structure and process (recruiting and vetting peer listeners, training, supervision)	
Formal request to be connected with a listener	
Active & cooperative learning	
Ongoing training opportunities	

Ethical and Legal Considerations

Ethical and legal concerns were a key area of interest for PWSRCAC and one that permeates training, supervision, and program design. While this was a key area of interest for PWSRCAC as stated in the Request For Proposals, each program interviewed did not express ongoing concerns because:

a. The peer listener model was very prescriptive, listening was done in a group setting in a disaster center– *NOVA Crisis Response Team*
b. There was a formalized process for applying to be connected with a peer listener, limit the length of the contact between listener and receiver, and had regular supervision by a credentialed professional - *UM CAPS and Stephen Ministries.* These were also recognized as best practices within the literature review curriculums, *Community Based Psychological First Aid and Southern Plains Tribal Health Board Peer Specialist Program.*

Programs emphasized the role of peer listeners as listeners and peer supporters not counselors, and received training and the signs of and how to refer people to additional mental health services. Programs emphasized program design elements as a way of mitigating ethical and legal concerns:

a. Selection of peer listeners
b. Initial training
c. On-going training, supervision, and review
d. Supervision by mental health professional or credentialed professional

One organization said the legal concern that it had was in tracking the names of the care receivers. They chose not to do this because the researcher associated with the peer listening program had been subpoenaed in a civil case(s) regarding who received help.

Recommendations to Build Forward

Recommendation 1: Select an approach and design based on your desired impact and resources.

The PWSRCAC's Peer Listener Training Manual describes a program consistent with the ongoing, long-term disaster response approach that results in community resiliency. The program's stated goal was to train enough leaders so that the cohort of trained listeners can respond as a crisis team to disasters, continuously train community members as peer listeners, support a therapeutic community, and be available for subsequent disasters. This is consistent with both the stakeholders' vision and with best practices in disaster response.

However, the challenge in the successful implementation of this approach is relationships and resources. Best practices for programs that do long-term, ongoing community listening and the long-term disaster approach require ongoing peer listening supervision and training. PWSRCAC staff and stakeholders repeatedly identified resource limitations and a boundary limitation within PWSRCAC's mission and domain for this program and the resource limitations generally for mental health in the region.

PWSRCAC has sought to overcome the limitation of their program budget resources by making a 2-hour set of videos widely available through posting on Facebook in 2010 and, in 2016, by changing the program model to a train-the-trainer model. The use of a train-the-trainer model was intended to use PWSRCAC's resources to train community leaders and professionals, so that they could offer the training in their respective communities.

However, stakeholder interviews revealed that without additional support and resources, trained participants felt ill equipped to execute the training and develop a team of trained listeners. Only one pair of participants was able to execute a community training. Without additional infrastructure, follow up, or resources, the train-the-trainer model did not accomplish the goal of many, diverse, trained peer listeners required for the region to be served, or to know to what extent the training meets the community care that the approach seeks to deliver.

To date, resource allocation has not matched with the program approach and scope as described in the manual and defined as priorities by key stakeholders.

With the Current Resources and Little Other Change What Can Be Done?

The goal and scope of the PWSRCAC Peer Listener program would be redefined and narrowed. There are multiple options that can be explored in this case. One option might be that PWSRCAC

could contract with another organization, such as National Organization for Victim Assistance (NOVA), to provide training. NOVA's Crisis Response Team is a Group B approach, or short-term, initial disaster response. NOVA would deliver training using their own curriculum to people within the Prince William Sound region. Once trained, those residents could be deployed for disasters in other parts of the region or the country or when a technological disaster occurs. This listening would happen in the context of a disaster center in the immediate aftermath of a disaster. In the case of a technological disaster in the Prince William Sound region, NOVA trained listeners from other communities could be brought to the region to support the local listeners and mental health professionals. In the case of NOVA, some states do already have their own locally trained teams. Florida is the best example, with 1,600 trained individuals in their state. The state teams have regionalized and they respond to disasters in the state, from the Surfside building collapse to hurricanes.

Additional Scope Questions for Consideration by PWSRCAC

Both the literature review and the program scan included programs in which professionals (health care, mental health, schools, first responders, etc.) were training in psychological first aid as part of their disaster response or other high-risk for trauma scenarios.

- When is a direct aid model with professionally trained healthcare workers helpful? The Disaster First Aid Field Operations Manual was designed specifically for this and serves as a starting point to approach, if desired.
- When is a robust community listening program most helpful? PWSRCAC's manual lays out a community peer listening training model with a strong theory base that provides this.
- Where, if at all, is there space for a hybrid model that includes both direct aid by helping professionals and a community listening model?

Recommendation 2: Build relationships and create partnerships to accomplish program goals and execute selected program approach.

Part of the creative solution to the challenge is to **build relationships for collaboration and partnership toward a coalition** embodying shared values and objectives. Mississippi-Alabama Sea Grant Consortium, who adopted the PWSRCAC model for short-term, initial disaster response (Group B), attributed its success in training peer listeners widely throughout the region to the relationships the staff built when carrying out other aspects of its mission such as community education about disasters and disaster preparedness. Mississippi-Alabama Sea Grant and Stephen Ministries both train large groups of people from many communities and may offer their expertise in this area.

Best practice peer listening models throughout our research indicated **a clear lead organization and clear partnerships with well identified roles which may be well met by the establishment of a formal coalition** to support peer listening programs. Consider that

partnerships could provide opportunities for funding that these organizations could get for doing this work. PWSRCAC will need embedded leaders/community leaders as they revise program design and training materials. PWSRCAC will likely need to establish new relationships within its own communities and outside of them to do this. Below are potential region and statewide partners, many identified in the stakeholder interviews, to provide necessary resources and effective crisis mobilization response:

1. Local
   a. Local counseling services, for example Valdez Counseling Center
   b. Each geographic and Alaska Native community
   c. First responders and emergency personal
   d. Schools and churches/faith institutions
2. Regional/Statewide
   a. Alaska disaster preparedness center-statewide or regional disaster response teams. The State of Alaska Department of Public Health is one entity that provides resources for this.
   b. Alaska Psychological Association Disaster Response Network: The Disaster Response Network (DRN), created by the American Psychological Association (APA), encourages licensed psychologists and mental health providers to join in partnership with the American Red Cross and other state and local agencies to provide pro bono mental health services to victims and responders of a disaster.
3. Larger training opportunities and resources listed or included in the Resources materials provided through this project.

"It would've been better if we had this in place during the pandemic."

–Stakeholder Interview 6

An added benefit to creative resource sharing and coalition formation can be that peer listeners activate their skills in response to other community crises and general wellness needs of their social networks.

Recommendation 3: Program Design–Peer Listeners

"Training and Accreditation: Peer supporters should: (a) be trained in basic skills to fulfill their role (such as listening skills, psychological first aid, information about referral options); (b) meet specific standards in that training before commencing their role; and (c) participate in on-going training, supervision, review, and accreditation."

– Guidelines for Peer Support in High-Risk Organizations: An International Consensus Study (2012), page 7.[13]

Once the approach and scope are confirmed and aligned, PWSRCAC can develop these aspects of the program:

a. Eligibility and recruitment of peer listeners
b. A plan for vetting and recruiting of listeners
    i. The UM CAPS program shared their Peer Counselor Agreement Form.
c. A plan for maintaining relationships between listeners, as well as ongoing peer listener support.
    i. Create a cohort of listeners and get clarity about which organization is responsible for maintaining ongoing training and relationship building as well as how to best use virtual and in-person methods for this.
d. Build a structured outreach plan to involve communities named as priorities.
e. Decide how peer listeners get connected to care receivers. Examples from our program scan:
    i. NOVA - provides short-term crisis response listening at disaster centers.
    ii. Stephen Ministries - Care receivers apply and are screened before being connected to a listener.
    iii. The UM CAPS Program - Care receivers fill out Peer Counseling Interest Form.
    iv. The original PWSRCAC curriculum shared peer listeners would be placed in specific places at specific times so their availability could be communicated to community members.

Regardless of the approach and scope selected, **more support to peer listeners is required.** Forty percent of stakeholder interviewed indicated that it was difficult to respond to other's trauma while also experiencing their own trauma. They also expressed uncertainty about when/how/with whom to use the skills or even how to let people know they had the skills. We encourage the PWSRCAC to review some of the best practices found in Groups B and C around immediate crisis and initial disaster response found in the Nova, Vibrant, Red Hook, and Community Based Psychological First Aid programs as a way to potentially relieve immediate trauma in the aftermath of a disaster. The immediate disaster response strategy in some of these models could allow time for community peer listeners to be gathered, hold training sessions, and become organized while immediate response teams begin to provide care. The literature review showed that in-person and virtual options, and supervised and self-directed communities are all viable options for effective support during crisis response and for ongoing work as peer listeners.

Recommendation 4: Program Design–Training Curriculum

There is a rich array of curriculum available to learn from and adapt to update PWSRCAC training curriculum. This includes "Community Based Disaster First Aid," a book which is a comprehensive tool to develop training material and covers required topics and designed specifically for disaster response, other curriculum shared in the appendices: the Psychological First Aid materials, NOVA,

Red Hook, Stephen Ministries and UM CAPS, and the Peer Listening Program Guideline developed by a team of 82 professionals in the field of peer support. While not an exact match in scope and design, it is a succinct list of key recommendations by a larger group of trained professionals (Appendix E).

Within those resources and in hand, integration of the below considerations will increase the effectiveness and impact of the training:

a. Revise program design to formalize a **peer listener support structure** and ensure all aspects of the program are **trauma-informed.**
b. Rewrite the curriculum pedagogy to be at least 60/40 didactic versus role play in presentation and teaching. Increasing the **active learning** aspect of the training program will strengthen the retention of skills.
c. Separate any peer listener training program from the train-the-trainer program.
d. To fulfill the PWSRCAC's Peer Listener Program purpose, **training must be more frequent** as well as match program approach.
e. Make clear to peer listeners and in materials that peer listening is a skill to use in everyday life, and can be activated in a crisis or disaster. This everyday use addresses community resiliency and makes it possible for these skills to be more effectively used in a disaster.

Fifty percent of all stakeholders interviewed indicated that they would participate in more training in peer listening. Nearly all stakeholders identified the need for the Peer Listener Program to be a consistent presence in the communities which speaks to frequency of training, ongoing support to and connections among trained peer listeners. One stakeholder stated that so much happened in a short period of time that it was hard to remember what was learned, a comment that connects to structure of the initial training and training pedagogy.

Recommendation 5: Cultural competency and relevancy integrated at each stage of planning, design, implementation, and evaluation.

Through stakeholder interviews, 60% of interviews discussed the uniqueness of the Prince William Sound region and the disparity between communities, as well as the physical distance between communities. This was named as one of the main considerations when building a quality peer listening model. Fifty percent talked about the importance of having culturally competent listeners who live in the Prince William Sound region.

Stakeholders repeated that they saw the need to connect with each community and institutions within each community such as churches, counseling organizations, and Alaska Native groups in order to spread the skill of peer listening widely.

In order to expand the program's ability to reach more people affected by disasters we recommend and encourage broader community engagement with Alaska Natives and other members of the diverse communities in the next stage of program planning. Stakeholders consistently noted the diverse culture and community needs of the area.

We suggest investing in a community-integrated planning and implementation process to ensure that program design responds to geographic, cultural, and community diversity. This response would address another need identified by stakeholders, the literature review, and organizational interviews – that the program is reflective of and responsive to the 19 Alaska Native communities and the diversity found in the culture, professions, sizes, and distances between communities. Community Based Psychological First Aid and the Psychological First Aid Field Op guide both identify local context as essential to peer listening programs. Cultural context additions based on a new process with key community and cultural, tribal leaders should significantly shape the next interaction of the program.

The Southern Plains Tribal Health Board Peer Specialist Program provides a cultural competency assessment for the beginning of program design. This includes:

1. People who run the program receive cultural competency training related to the population served.
2. The racial/ethnic/gender composition of the team has been assessed.
3. The program regularly assesses whether its activities are valued by different tribal affiliations.

Recommendation 6: Develop program monitoring and evaluation

> *"Program evaluation: Peer support programs should establish clear goals that are linked to specific outcomes prior to commencement. They should be evaluated by an external, independent evaluator on a regular basis and the evaluation."*
>
> *– Guidelines for Peer Support in High-Risk Organizations: An International Consensus Study (2012), page 7.*[13]

One of the biggest gaps we uncovered in the field of peer listening and disaster crisis response was around evaluation. Nearly every program we interviewed desired more evaluation work and a greater understanding of the effectiveness of their programs and work. With PWSRCAC 's initial leadership in this field, we recommend the following as it continues to lead:

a. Develop a program quality assessment matrix consistent with PWSRCAC's self selected approach, design, and best practices. This answers a critical question (i.e., did we do what we set out to do?) and provide opportunities to celebrate success and reflect on planned versus actual implementation of the program.

i. *An example of a few items for this matrix would be:* assessment of the diversity of trained peer listeners against the diversity of the communities to be served by PWSRCAC, whether the training delivered covered all the topics selected and with what depth, trainee self-assessment of their preparedness to be peer listeners as a result of the training.

b. Adopt a set of program monitoring (delivered activities and outputs) and outcome measurement tools. While some external evaluations can be cost prohibitive, these tools can be designed to be practically applied within the resources of the PWSRCAC. At the 2016 train-the-trainer workshop, the evaluation used a pre/post knowledge and satisfaction with the experience assessment that provided affirmation of strengths and areas to improve.

    i. *An example of a few data points for this would be:* the number of people trained, the length of the training, the length of time on each topic of the training, the number of people the peer listeners talk to, whether peer listeners referred people to additional mental health services.

c. Healthy partnership and cross community coordination assessment can aid in the ongoing retention of partners and resource development. This returns to the question of who holds the program and the mechanisms for cross community coordination that can lead to a large and diverse body of trained peer listeners and for discussion on resources needed for this and ways in which organizations with stretched resources can support the work even when they can share little staff time or organizational resources.

    i. *An example of a few items that could be included in this are:* each partner organization rates their satisfaction with the partnership on key indicators of healthy partnership that the partners can set together such as frequency of meetings, shared decision making, clarity of roles and responsibilities within the partnership.

Additional resources shared by the organizations interviewed and found in Appendix A: Annotated Literature Review and the Resources materials provided from this project.

References

Psychological First Aid Books and Manuals

1. Everly, George S Jr., Jeffrey M. Lating. (2022). "The Johns Hopkins Guide to Psychological First Aid," second edition [note: not yet released, there is a 2017 edition available].

2. Jacobs, Gerard. (2016). "Community-Based Psychological First Aid: A practical guide to helping individuals and communities during difficult times."

3. National Child Traumatic Stress Network and National Center for PTSD. (2006). "Psychological First Aid, Field Operations Guide," 2nd ed.

4. Southern Plains Tribal Health Board. (2020). "Peer Support Toolkit."

5. Schmidt, Robert W., Sharon L. Cohen. (2020). "Disaster Mental Health Community Planning A Manual for Trauma-Informed Collaboration." Routledge, NY.

6. Vernberg, E.M., A.M. Steinberg, A.K. Jacobs, et al. (2008). "Innovations in disaster mental health: Psychological first aid." Professional Psychology: Research and Practice, 39(4): 381-388.

Articles

7. Archer, Diane and Somsook Boonyabancha. (2011). "Seeing a disaster as an opportunity – harnessing the energy of disaster survivors for change." Environment & Urbanization, 351 Vol 23(2): 351–364.

8. Banbury, Annie, Sonja Pedell, Lynne Parkinson, and Louise Byrne. (2021). "Using the Double Diamond model to co-design a dementia caregivers telehealth peer support program." Journal of Telemedicine and Telecare, Vol. 27(10) 667–673.

9. Cheng, Pu et al. (2020). "COVID-19 Epidemic Peer Support and Crisis Intervention Via Social Media." Community Mental Health Journal, 56:786–792.

10. Cherry, Katie E and Allison Gibson, Editors. (2021). "The Intersection of Trauma and Disaster Behavioral Health." Springer.

11. Choi, Y., H. Jung, E. Choi, & E. Ko. (2021). “Disaster Healthcare Workers’ Experience of Using the Psychological First Aid Mobile App During Disaster Simulation Training.” Disaster Medicine and Public Health Preparedness, 1-7.

12. Colder Carras, Michelle, Mathew Bergendahl, and Alain B. Labrique. (2021, March 11). “Community Case Study: Stack Up’s Overwatch Program, an Online Suicide Prevention and Peer Support Program for Video Gamers.” Frontiers in Psychology.

13. Creamer, Mark C. et al. (2012). “Guidelines for Peer Support in High-Risk Organizations: An International Consensus Study Using the Delphi Method.” Journal of Traumatic Stress, 25, 134–141.

14. “Disaster Mental Health and Positive Psychology-Considering the Context of Natural and Technological Disasters.” (2016, Dec.). Journal of Clinical Psychology, Vol. 72 Issue 12.

15. Gruebner, Oliver, et al. (2017, July 19). "A novel surveillance approach for disaster mental health." PLoS ONE, vol. 12, no. 7, p. e0181233. Gale Academic OneFile.

16. Jacobs, Gerard A. et al. (2016). “Disaster Mental Health and Community-Based Psychological First Aid: Concepts and Education/Training.” Journal of Clinical Psychology, vol. 72(12), 1307–1317.

17. Johnstone, Margaret. (2007, Feb.). “Disaster Response and Group Self-Care.” Perspectives in Psychiatric Care Vol. 43, No. 1.

18. Peek, Lori and Simone Domingue. (2020). “Recognizing Vulnerability and Capacity: Federal Initiatives Focused on Children and Youth Across the Disaster Lifecycle.” Chapter in Haeffele, Stefanie and Virgil Henry Storr, editors. (2020). “Government Responses to Crisis.” Mercatus Studies in Political and Social Economy.

19. Picou, Steven J. (2010). “The BP Catastrophe and Sociological Practice Mitigating Community Impacts through Peer-Listener Training.” 2010 AACS Presidential Address, St. Louis.

20. Powell, Tara M. and Tuyen Bui. (2016). “Supporting Social and Emotional Skills After a Disaster: Findings from a Mixed Methods Study.” School Mental Health, 8: 106–119.

21. Slack, Tim, Jaishree Beedasy, Thomas Chandler, Kathryn Sweet Keating, Jonathan Sury, and Jeremy Brooks. (2021). “Family Resilience Following the Deepwater Horizon Oil Spill:

Theory and Evidence." In Stout, Mike and Amanda W. Harrist, editors. (2021). "Building Community and Family Resilience: Research, Policy and Programs." Springer.

22. Van Dyck, Laura, Kirsten Wilkins, Marcia Mecca, Chadrick Lane, and Michelle Conroy. (2021, April). "Social Connections for Seniors During COVID-19: An Online Psychoeducation and Peer Support Program." American Journal of Geriatric Psychiatry 29:4S. Poster Number: NR-31.

23. Smith, Daniel and Daniel Sutter. (2013). "Response and Recovery After the Joplin Tornado." The Independent Review, pp. 165-188.

Appendix A: Annotated Bibliography

Psychological First Aid Books and Manuals

1. Everly, George S Jr., Jeffrey M. Lating. (2022). "The Johns Hopkins Guide to Psychological First Aid," second edition [note: not yet released, there is a 2017 edition available].
   Psychological first aid (PFA) is designed to mitigate the effects of acute stress and trauma and assist those in crisis to cope effectively. PFA can be applied in emergencies, including disasters, terrorist attacks, and the COVID-19 pandemic. The text describes the principles and practices of PFA in an easy-to-follow, prescriptive, and practical manner. Informed by current events. The 2nd edition has new chapters on: cultural awareness, PFA considerations with children, and the use of PFA to facilitate community mental health and resilience. It is aimed at mental health practitioners, first responders, and global health disaster teams, and is beneficial for those with little or no previous mental health training. They have titled their method RAPID PFA.

2. Jacobs, Gerard. (2016). "Community-Based Psychological First Aid: A practical guide to helping individuals and communities during difficult times."
   Psychological First Aid (PFA) draws on human resilience and aims to reduce stress systems and help those affected recover. The text presents a proven method teaching lay people to help alleviate the mental health effects of disasters, terrorist attacks, civil unrest, and other community stressors. The model, developed over 20 years, has been taught in over 30 countries. The book is written for people without a mental health background and provides extensive resources for learning. They are adaptable to individual communities or cultures. It outlines practices for self-care of peer listeners as they help others, in order to prevent burnout, and includes case studies. The author is the Director of the Disaster Mental Health Institute (DMHI) and a professor in the doctoral Clinical Psychology Training Program at The University of South Dakota. He received his Ph.D. in clinical/community psychology.

3. National Child Traumatic Stress Network and National Center for PTSD. (2006). "Psychological First Aid, Field Operations Guide," 2nd ed.
   This guide is directed at providing practical actions, a set of core actions, and understanding trauma responses for mental health and other disaster response workers in the immediate response to ecological and technical disasters. While brief

as compared to the Jacobs book, it is useful for identifying core skills and developing specifics of a training manual for the program. Another article listed here reviews this guide and asserts that while, the program is not evaluated as such, it uses all the current academic evidence of the time (*see Vernberg)*.

4. Southern Plains Tribal Health Board. (2020). "Peer Support Toolkit." https://issuu.com/spthb/docs/peer_support_toolkit_booklet
   The information contained provides an overview about the effectiveness of peer support programs, important core roles, and items to consider for implementing a successful peer program. The peer support program described is delivered by people with lived experiences of recovery, mental illness, and/or addiction and delivered in a behavioral health setting. Because it is written by and for Indigenous care providers, it provides an example for the PWSRCAC to invoke in its manual.

5. Schmidt, Robert W., Sharon L. Cohen. (2020). "Disaster Mental Health Community Planning A Manual for Trauma-Informed Collaboration." Routledge, NY.
   The chapters outline how to prepare, develop, and implement a trauma-informed collaborative process that prioritizes lasting emotional well-being along with survivors' short-term needs. The manual demonstrates how to form this partnership through effective communication, assess those individuals at greatest risk of distress, and deliver trauma-specific treatment. It holds useful information about trauma that can be communicated and incorporated in program materials. While the focus is on community-level response planning, it demonstrates where peer listening fits into a community response model.

6. Vernberg, E.M., A.M. Steinberg, A.K. Jacobs, et al. (2008). "Innovations in disaster mental health: Psychological first aid." Professional Psychology: Research and Practice, 39(4): 381-388.
   This article gives an overview of the developmental process, guiding principles, and core actions of the Psychological First Aid Field Operations Guide (PFA Guide), which provides guidance for practitioners in responding to immediate mental health needs of children, adults, and families who have recently experienced a disaster or terrorist event. Issues in training, provider self-care, and evaluation research are also presented. It concludes that the PFA Guide presents approaches thought to be most consistently supported by current research and practice so that they can be taught, used, and evaluated in field settings. The PFA Guide represents a sustained

collaborative effort to define current evidence-informed best practices that can be utilized now by practitioners involved in disaster mental health responses.

Additional Articles

7. Archer, Diane and Somsook Boonyabancha. (2011). "Seeing a disaster as an opportunity – harnessing the energy of disaster survivors for change." Environment & Urbanization, 351 Vol 23(2): 351–364.

The traditional response to disasters is to provide immediate relief, without considering how the process of rebuilding lives and communities can be a positive opportunity for change. This opportunity can be facilitated in two ways: first, by having a clear understanding of how disaster survivors are not victims but agents for change; and second, by providing the tools and techniques to facilitate the change process. Case studies from Asia demonstrate how disaster-affected communities have rebuilt not only their homes but also their livelihoods, and have been empowered as a result. The authors emphasize that a community with a sense of the collective is better able to respond when disaster occurs. However, building an empowered, collective response to the disaster can begin in the earliest stages of a disaster. This constitutes moving beyond 1:1 assistance to more collective support with working groups of survivors addressing different aspects of need resulting from the crisis. The case studies included here describe how it occurred.

8. Banbury, Annie, Sonja Pedell, Lynne Parkinson, and Louise Byrne. (2021). "Using the Double Diamond model to co-design a dementia caregivers telehealth peer support program." Journal of Telemedicine and Telecare, Vol. 27(10) 667–673.

   This paper reports the co-design process using the Double Diamond model by telehealth and the impact and experiences of participants. Co-design involves affected parties to ensure the results meet the needs of the people for whom it is designed. The Double Diamond model guided the co-design process, which has four phases: discover, define, develop, deliver. Six dementia caregivers were recruited from dispersed locations with diverse characteristics. The process identified eight key topics to be included in a program to be delivered by telehealth. Participants reported the technology did not detract from the co-design and at times aided it, despite some technical problems. The program completed through co-design led to a self facilitated support group that continued for 2.5 years. Semi-structured interviews with participants were completed at the end of the project. All reported high levels of group connectedness, feeling supported, and transfer of knowledge and skills. This paper highlights a process which can be used to revise the peer

listening program with members of the community at the center and demonstrates the longevity of such work outside of facilitation by professionals.

9. Cheng, Pu et al. (2020). "COVID-19 Epidemic Peer Support and Crisis Intervention Via Social Media." Community Mental Health Journal, 56:786–792.

This article describes a peer support project developed and carried out by a group of experienced mental health professionals from USA, Canada, and Australia, all of whom spoke Chinese, organized to offer peer psychological support from overseas to healthcare professionals on the frontline of the COVID-19 outbreak in Wuhan, China. This pandemic extremely challenged the existing health care systems and caused severe mental distress to frontline healthcare workers. The authors describe the infrastructure of the team and a novel model of peer support and crisis intervention that utilized a popular social media application (WeChat) on smartphones. The article lists group and service operation details, the tools used, and the parameters the group worked within. This was short-term support with coverage 24/7 for the duration offered. It included individual and group support and adapted to culture, stigma, and political climate. The model for intervention can be useful for the PWSRCAC program.

10. Cherry, Katie E and Allison Gibson, Editors. (2021). "The Intersection of Trauma and Disaster Behavioral Health." Springer.

The entire book is dedicated to state-of-the art knowledge concerning trauma, resilience, and post-disaster behavioral health. The chapters bring interdisciplinary perspectives that shed new light on the pressing and perennial challenges. The chapters can be mined for information on theory, trauma effects, programs, and differences across the lifespan.

11. Choi, Y., H. Jung, E. Choi, & E. Ko. (2021). "Disaster Healthcare Workers' Experience of Using the Psychological First Aid Mobile App During Disaster Simulation Training." Disaster Medicine and Public Health Preparedness, 1-7.

This study was designed using qualitative research methodology with focus group interviews. The participants were 19 disaster healthcare workers from community mental health service centers who attended disaster simulation training in flood, fire, or leakage of hazardous chemicals. Before the simulation, participants were provided the PFA mobile app and allowed to practice the PFA techniques to apply them during the simulation. Data were collected through focus group interviews and qualitatively analyzed using the content analysis method.

The findings were divided into six categories: experience in realistic disaster situations, satisfaction with education methods using a mobile app, effectiveness of the PFA app in disaster relief, confidence in disaster relief by integrating experience and knowledge of the PFA app, self-reflection as a disaster healthcare worker, and identifying limitations and making developmental suggestions. Based on the participants' developmental proposals in this study, the disaster simulation training, incorporating improvements in the disaster simulation training and the PFA app features, will serve as a new framework for disaster support education and systematic mental health services to survivors by disaster healthcare workers.

12. Colder Carras, Michelle, Mathew Bergendahl, and Alain B Labrique. (2021, March 11). "Community Case Study: Stack Up's Overwatch Program, an Online Suicide Prevention and Peer Support Program for Video Gamers." Frontiers in Psychology.

Traditional mental health services are often not enough to meet the needs of people at risk for suicide, especially in populations where help-seeking is stigmatized. Stack Up, a nonprofit veteran organization whose goal is to use video games to bring veterans together, recognized a need in its gaming-focused online community and created the Overwatch Program. This suicide prevention and crisis intervention program is delivered entirely through the internet by trained community members through Discord text and voice chat. The article describes the context and features of the program, an ongoing evaluation project, and lessons learned.

The program described provides valuable input in the PWSRCAC Peer Listener Program in that it takes peer support from an exclusively 1:1 telehealth delivery (text messages, online chat, and live phone calls) to include groups and thus addressing issues of belonging and community that may be applicable in a disaster response. Further, the use of Discord with its multiple modes of interaction could be used to provide training, resources, and ongoing connection for peer listeners. The program is supervised by a trained professional. Whether or not Discord could be applied to provide the peer listening services to the community is worth further investigation as an additional benefit of Discord is the option of anonymity by users who self-selected names, thus reducing one aspect of discomfort for those who are hesitant about help seeking.

13. Creamer, Mark C. et al. (2012). “Guidelines for Peer Support in High-Risk Organizations: An International Consensus Study Using the Delphi Method.” Journal of Traumatic Stress, 25, 134–141.

From 17 countries, 92 clinicians, researchers, and peer-support practitioners took part in a 3-round web-based Delphi process rating the importance of statements generated from the existing literature on peer support mental health programs. Consensus was achieved for 62 of 77 (81%) statements. Based upon these, 8 key recommendations were developed covering the following areas: (a) goals of peer support, (b) selection of peer supporters, (c) training and accreditation, (d) role of mental health professionals, (e) role of peer supporters, (f) access to peer supporters, (g) looking after peer supporters, and (h) program evaluation. This international consensus may be used as a starting point for the design and implementation of future peer-support programs in high-risk organizations.

14. “Disaster Mental Health and Positive Psychology-Considering the Context of Natural and Technological Disasters.” (2016, Dec.). Journal of Clinical Psychology, Vol. 72 Issue 12.

This entire issue of eight articles is devoted to the topic. It includes BP Deep Horizons oil spill event research on trauma impacts on individuals and children.

15. Gruebner, Oliver, et al. (2017, July 19). "A novel surveillance approach for disaster mental health." PLoS ONE, vol. 12, no. 7, p. e0181233. Gale Academic OneFile.

Researchers applied an advanced sentiment analysis on 344,957 Twitter tweets in the study area over eleven days, from October 22 to November 1, 2012, to extract basic emotions, a space-time scan statistic (SaTScan) and a geographic information system (QGIS) to detect and map excess risk of these emotions. They found sadness and disgust were among the most prominent emotions identified; noted 24 spatial clusters of excess risk of basic emotions over time: four for anger, one for confusion, three for disgust, five for fear, five for sadness, and six for surprise. Of these, anger, confusion, disgust, and fear clusters appeared pre-disaster, a cluster of surprise was found peri-disaster, and a cluster of sadness emerged post-disaster.

16. Jacobs, Gerard A. et al. (2016). “Disaster Mental Health and Community-Based Psychological First Aid: Concepts and Education/Training.” Journal of Clinical Psychology, vol. 72(12), 1307–1317.

Psychologists can be an important resource assisting in psychological support for individuals and communities, in preparation for and in response to traumatic events.

Disaster mental health and the community-based model of psychological first aid are described herein. The National Preparedness and Response Science Board recommended that all mental health professionals be trained in disaster mental health, and that first responders, civic officials, emergency managers, and the general public be trained in community based psychological first aid. Education and training resources in these two fields are described to assist psychologists and others in preparing themselves to assist their communities in difficult times and to help their communities learn to support one another.

17. Johnstone, Margaret. (2007. Feb.). "Disaster Response and Group Self-Care." Perspectives in Psychiatric Care Vol. 43, No. 1.

This article reports on group support using Psychological First Aid during Katrina relief work. It explores this issue from personal experience and a theoretical perspective. The author provided presented-centered therapy, which focuses on effects of trauma without relieving the trauma by discussing details of it, to victims. She reported that the peer support model of debriefing with members of her team that provided disaster assistance had a significant impact on the quality of their work and on their personal coping skills. The use of group work with disaster and trauma survivors had an immediate positive impact and lasting consequences in preventing post-traumatic stress disorder for both participants she worked with and herself as a provider.

18. Peek, Lori and Simone Domingue. (2020). "Recognizing Vulnerability and Capacity: Federal Initiatives Focused on Children and Youth Across the Disaster Lifecycle." Chapter in Haeffele, Stefanie and Storr,Virgil Henry, editors. (2020). "Government Responses to Crisis." Mercatus Studies in Political and Social Economy.

The chapter begins with a literature review of the effects of disasters on children, noting that most of the literature has been since 2010 and around a small number of events. It then goes on to summarize 11 federal programs to engage children and youth in disaster response/preparedness and 17 federal programs that address organizations who work with youth. The limitation of most of these programs is the individual nature, rather than community collective, response to disaster. The Youth Leadership Council suggests some ideas for program design in the PWSRCAC's work in disaster preparedness/response that develop leadership and hold the potential for building collective responses. The YPC typically includes between 10 and 15 youth leaders who are identified through a competitive application process to participate in the program. These YPC members are invited to attend an annual meeting, held in

the summer in Washington, D.C., where they receive training and mentoring from leading emergency management professionals and child protection experts. During their two-year appointment on the council, all of the YPC members are encouraged to develop and launch their own local- or national-level disaster preparedness project. They are also regularly invited to provide input and a youth perspective on new programs and initiatives.

19. Picou, Steven J. (2010). “The BP Catastrophe and Sociological Practice Mitigating Community Impacts through Peer-Listener Training.” 2010 AACS Presidential Address, St. Louis.

Written by one of the most cited authors on mental health needs in technological disaster, the article provides a summary of the significant ecological and community damage from the BP oil spill in the Gulf of Mexico. It gives an overview of the Gulf Oil Spill peer listening program, how it was adapted from the PWSRCAC program and its components. They offered the program 26 times and trained over 600 peer listeners in 2010. Training evaluations reported that the training was perceived as well organized, provided useful information, and would be an asset. The training was 5 hours with 4 sections: specific trauma effects of technological disasters, skills in peer listening skills building, recognizing common symptoms and concerns, how to provide support by building a relationship, and providing resources.

20. Powell, Tara M. and Tuyen Bui. (2016). “Supporting Social and Emotional Skills After a Disaster: Findings from a Mixed Methods Study.” School Mental Health, 8: 106–119.

This paper explores the impact of a school-based psychosocial curriculum entitled Journey of Hope (JoH). This eight-session intervention led by professional facilitators (8 1-hour sessions to groups of 8-10 youth K-12 grades) attempts to reduce the impact of a disaster by enhancing protective factors such as social support, coping, and psycho-education. JoH focuses on the disaster itself and secondary adversities that young people may have experienced as a result of the disaster such as loss of home, changing schools, and community devastation. The evaluation study was conducted in the 2014–2015 school year after an EF5 tornado struck Moore, Oklahoma, killing 24 people, injuring 377, and destroying two schools. This mixed methods study employed quantitative and qualitative measures to examine the impact of the JoH intervention. Quantitative measures examined coping, general self-efficacy, prosocial behaviors, and overall distress with N=110. Qualitative data were obtained through interviews with N = 16 students after participation in the JoH.

Results indicated a significant increase in positive coping skills including communication and tension management and prosocial behaviors from baseline to posttest. No significant differences were found on self-efficacy or overall distress. Content analysis was conducted to determine qualitative results. Themes that emerged from the qualitative interviews suggested participation in the Journey of Hope enhanced peer relationships and helped participants identify how to manage emotions such as anger, anxiety, and grief.

21. Slack, Tim, Jaishree Beedasy, Thomas Chandler, Kathryn Sweet Keating, Jonathan Sury, and Jeremy Brooks. (2021). "Family Resilience Following the Deepwater Horizon Oil Spill: Theory and Evidence." In Stout, Mike and Amanda W. Harrist, editors. (2021). "Building Community and Family Resilience: Research, Policy and Programs." Springer.

The study used multi-stage sampling to select communities, census tracts, and households with children. The survey instrument covered topics such as direct and indirect oil spill exposure, physical and mental health status, perceptions of recovery, demographic data, and a range of characteristics theoretically linked to social vulnerability and resilience. Data was collected in 2012, 2014, 2016, and 2018, from the same households. Their results suggest that direct and indirect family exposure to the oil spill was correlated with greater child psychosocial health challenges four and six years after the disaster began. Further, this research points to the role of cumulative risk for families in a disaster-prone setting and disruption of cultural lifeways, both of which research has suggested pose threats to family resilience. The practical implication is that building adaptive capacity for families and communities involves the development of sustainable skills, shared resources, and organizational structures by fostering knowledge, leadership, and the ability to represent diverse group interests. The Peer Listening program is specifically cited as one example of this. Interventions in school settings as effective for fostering resilience in youth following an adverse event is another.

22. Van Dyck, Laura, Kirsten Wilkins, Marcia Mecca, Chadrick Lane, and Michelle Conroy. (2021, April). "Social Connections for Seniors During COVID-19: An Online Psychoeducation and Peer Support Program." American Journal of Geriatric Psychiatry 29:4S. Poster Number: NR-31.

The Yale Department of Psychiatry implemented the Social Connections for Seniors During COVID-19 (SCSC) Program to provide older adults with a weekly online forum for education, peer support, and social engagement to address social isolation and

loneliness which was exacerbated by the COVID-19 pandemic. Eight of 11 participants responded to an end of program survey and reported that they felt less isolated and had learned important information. While a small sample size with a different program objective, it affirms that virtual programs can be implemented and valued by members of the community who did not grow up with technology as their norm.

23. Smith, Daniel and Daniel Sutter. (2013). “Response and Recovery After the Joplin Tornado.” The Independent Review, pp. 165-188.

The article explores the varied responses in the public and private sector to disaster recovery and their effect on communities emphasizing the necessity of a healthy institutional, social, and cultural environment prior to the post disaster response and recovery. The article goes on to describe the coordination needed to fully mobilize the support offered from around the world from the faith-based and voluntary sector, the business sector, and the public sector.

Appendix B: Peer Listener Program Interview Questions

Introduction of PDC, PWCRAC's history, and our research project over email. Review of the purpose at the start of the interview and what will be done with what they share about their program.

- Name, title, how long have you worked for the organization.
- What is the part of the program you are most proud of? In your opinion, what piece of the program should be implemented widely?
    - What best practices would you share?
- Program Scope
    - What are the geographic or identity parameters of your program?
    - How was the curriculum developed?
    - When was it developed? Has it been revised/when? Is there a regular revision update cycle?
    - Balance of theoretical underpinnings compared to role play/practice and therapeutic communication?
- Peer Listeners
    - How are peer leaders selected? Is there an application?
    - Are there partner organizations peer listeners are selected or recruited from?
    - How are they supervised? Can you share your support structure?
    - Is there continuing education?
    - What support to peer listeners receive?
    - How are peer listeners evaluated?
    - How do you retain peer listeners?
    - Is there a maximum number of peer listeners you can train in a year?
    - Do you utilize a train-the-trainer model?
    - Who can become a trainer? Is there a certification program?
- Program Data

    - How many peer listeners trained? How many people did they relate to this year?
    - How do you evaluate the program?
    - Does your program have any long-term data peer listeners or program participants? How do you track data?
- Organizational Capacity
    - How many staff members are allocated to the peer listener program?
    - What is the annual program budget?
    - Any other organizational investment?
- COVID-19 Pandemic Adaptation
    - Has this shifted your program delivery (i.e., virtual/hybrid instruction)?
- What is the growing edge for your program?
    - Trauma, disaster, pandemic, etc.
- Are you able to share any curriculum, agenda, or other supporting materials?
- Does your organization consult or offer training to other organizations?
    - If so, how does this relationship generally work? How are trained participants then supported?

Appendix C: Organizational Interview Summaries

NOVA Crisis Training Response Teams

The NOVA Crisis Response Team (CRT) Training provides caregivers with techniques to deliver critical emotional first aid to victims, survivors, and community members in the event of a mass-casualty or disaster (natural or technical). NOVA has over 30 years of field-tested best practices as a crisis management utility that includes trauma mitigation and education protocols.

Highlights

NOVA has trained over 17,000 CRT listeners. The concentration of listeners has allowed certain organizations or states to have their own teams that are ready to be deployed.

- Florida has 1,600 trained individuals in their state. They are regionalized and respond to instances of mass violence and disasters, including Surfside Building Collapse, Pulse Nightclub shooting, and all recent hurricanes.
- NOVA CRT listeners also responded to 9/11.

Year Founded	# Listeners	Hours of Training	# of People Served in Year
1975	17,000+	Initial: 24 hours Advanced: 24 hours	unknown

Best Practices as Recommended by the Organization

- *Fidelity to the model:* CRT listeners are trained to facilitate group and individual processes. Listeners must follow an established sequence – establish safety & security, ventilation & validation, and prediction & preparation. The CRT model can be provided individually or in groups.
- *Trauma informed:* NOVA CRT training and process is trauma informed and produced in conjunction with professional credentialing organizations for clinicians.
- *Listeners must utilize the tools before becoming a trainer:* Trainers are selected from participants who have completed basic training, advanced training, have multiple

instances of utilizing the skills in a traumatic event, and demonstrate an interest or ability in facilitation & training.
- *Credentialed CRT listeners:* By the end of this year, NOVA will have revived a crisis response credential program. To maintain the credential would require continuing education, to help CRT listeners professionalize and maintain their skills and abilities.

Program Scope

NOVA's CRT listeners provide direct services through individual and group crisis intervention sessions during the immediate aftermath of a mass casualty or natural or technical disaster. These teams could be state coordinated (e.g., out of a state attorney general's office) or local teams (e.g., a school district). The response can be scaled to the need, from one individual to thousands.

The CRT model is a community-based model. For CRT listeners, there is no clinical background or training required. The preference is for diverse teams – first responders, schools, community folks, hospital staff, clergy. Generally the CRT listeners are available in the short-term (up to one year) after a disaster.

Curriculum

NOVA CRT training participants have a minimum of 24 hours of skill-based, field-tested training. For basic level, 16 hours of online instruction (4 Hours/4 days), 5 hours of guided learning, and 3 hours of group work.

The model follows three phases:
- Safety & security – establish safety (physical) and security (emotional) with participants.
- Ventilation – utilize prompted questions to uncover what that they want CRIT listeners to know.
- Validation – validate their crisis experience.
- Prediction & preparation – accompany participants to imagine the future, hear concerns, and prepare them. Equip them with resources.

The NOVA CRT model does not take away or eliminate painful situations. The model is built to help people diminish suffering about painful situations.

In training, there is an interplay between practical skills and ideological underpinnings. After the 24 hours of basic training, the goal is to ensure participants can execute the model by the end of the training. They are trained on how to execute each of the three roles for group process – scribing, facilitation, and caregiving. Overall, the beginner training is 40 - 45% role play in group crisis intervention and 50-55% technical learning.

- **Training Day 1** – Includes heavy lectures on topics such as brain development, trauma, and the NOVA model as crisis intervention.
- **Training Day 2** - Most of the day is spent doing hands on exercises and practical skill building.
- **Training Day 3** - Participants execute the NOVA CRT model. The group engages in a role play scenario, in which trainees act as crisis intervention participants and facilitators, while being evaluated by NOVA CRT Trainers.

Trainers & Train-the-Trainer Program

Trainers can come from any profession – educators, mental health clinicians, etc. To become a trainer they must have gone through basic and advanced training, in addition to applying the skills by responding to crises. Then they shadow the trainers for the basic model and attend Train the Trainer (where they learn to train the basic model). Trainers must show interest in training and developing themselves as a facilitator. Trainers are working with adult learners for three straight days, 10-12 hours a day. This requires a certain and distinct skill set. The train-the-trainer program is currently on pause while NOVA revamps the program in order to develop more oversight mechanisms and data collection practices.

Occasionally, an institution is big enough to require their own in-house training team. An example is Houston Independent School district. They have over 300,000 students in over 285 buildings. They have their own trainers that train for the district.

The Peer Listeners

People become CRT Listeners normally by being affiliated with an organization that is organizing a disaster response crisis intervention team. The organization brings NOVA in to facilitate a training. The basic and advanced training are sequential; they are each 3-day (24 hours of training). The advanced goes into more specifics around culture, continuum of age, youth and elderly, and trauma. Common responses to trauma and how to manage mental health referrals is a part of basic training.

NOVA maintains some contact with trained listeners, but the primary responsibility for cultivating and supervising listeners falls with the supporting organization. In the case of a large-scale disaster, NOVA might deploy listeners to an area to relieve local listeners.

NOVA CRT skills are crisis intervention skills and can also be used on a smaller scale. Las Vegas Police Department CRT Listeners are trained to help other law enforcement officers manage a multitude of crises in their jobs and personal lives.

Program Data

The NOVA CRT program trains a minimum of 1,500 people per year. Prior to the pandemic, the number was closer to 2,000. The minimum is 25 participants per training. On average, NOVA facilitates 2-3 trainings per month.

NOVA does not have data on peer listener retention or activities of listeners once they are trained. The organizational focus is on training and requesting organizations are responsible for data collection and evaluation. NOVA does not currently have the capacity to offer ongoing supervision with individual cases.

When there is a crisis in an area, NOVA may reach out to one of its local organizations to support the ongoing crisis intervention efforts. Post the mass shooting in Las Vegas, NOVA deployed a team to take over to relieve local listeners. This also frees up mental health professionals to focus on people who need more ongoing care.

Considerations in Adopting or Adapting from this Program

The pandemic required that the CRT training be adapted for virtual instruction. One of the other major changes is the NOVA touchbase program, which serves as a peer-to-peer program internally. This allows listeners to get connected with another crisis responder to manage their own frustration and caseloads. Post disasters, they sometimes offer the touchbase program in communities, along with virtual education to understand crisis reactions during a disaster online. These changes have allowed NOVA to strengthen its model while adapting to the environment created by the COVID-19 pandemic.

Resources Shared or Available

1. 9 Commonly Asked Questions Regarding CRT
2. Basic CRT Training Agenda
3. Advanced CRT Training Agenda
4. NOVA CRT Training Measurable Objectives, by basic and advanced

5. NOVA CRT Brochure
6. CRT Newsletter - December 2021

Interview

3/24/22, 75 minutes, Kellie Portman, Crisis Response Training Coordinator & Roger Roberts, Director of Crisis Response Services, Interviewed by Bianca Vazquez

Stephen Ministry

Stephen Ministry was created in 1975 by a clinical psychologist who also served as a pastor. The creator of the program responded to an appeal for community mental health programs where mental health professionals equipped non-professional. He realized that there were more people who needed accompaniment and listening than he would be able to do himself as one person and created the program we know as Stephen Ministry today.

Highlights

Year Founded	# Listeners	Hours of Training	# of People Served in Year
1975	13,000+ partner institutions 750,000 trained listeners	Leaders: 40 hours Listeners: 25 hours	No exact data, over 1.5 million

Best Practices

- Supervision must be regular and consistent. Supervision is done with a small group of peer listeners who meet for peer group accountability.
- Each listener attends twice monthly supervision and receives an opportunity every 6-8 weeks to participate in a deep dive about their experience.
- Listeners do not stay with a care receiver for longer than one year.
- Stephen Leaders receive 40 hours of training. They recruit and train listeners. Stephen Leaders interview someone before they are assigned to a listener to ensure it is not something beyond a listener's capacity (i.e., active substance abuse or untreated mental illness).

Program Design

There is a Stephen Ministry National Organization with 13,000+ partner institutions across the country, most of whom are churches. In its local iterations, Stephen Ministry has a two-tiered leadership model. Stephen Leaders guide the program and supervise the listeners. Stephen Listeners serve for two years and are paired up with an individual, aka “Care Receiver” who is undergoing some challenge or life transition. The average time that someone is listened to is six months to a year. Sometimes, the need for accompaniment is longer, for example a chronic illness. In that case, listeners are swapped at one-year intervals.

Stephen Ministry teams in a congregational setting are encouraged to provide listeners both within their institution and from the larger community. There are organizations that are not congregations or faith-based institutions, namely prisons. Within the prison system, the entire Stephen Ministry Program is duplicated. A chaplain or other staff person acts as and is trained as a Stephen Leader. The Stephen Leader works with Stephen Ministry staff to train inmates to serve as listeners. Stephen Leaders, who sign on for two years, are responsible for publicizing the program, recruiting and selecting listeners, training the listeners and getting them trained by Stephen Ministry, screening care receivers, and providing for supervision.

Stephen Leaders are responsible for recruitment of both listeners and “care-receivers.” They can come from the congregation or sponsoring institution, but Stephen Ministry encourages them to advertise in the community.

Curriculum

The training for Stephen Leaders is 40 hours. The training for Stephen Listeners is 25 hours. Stephen Leaders facilitate the Stephen Listener training with national staff.

The pedagogy of the training is primarily based on role play and interactive activities. Approximately, ½ of training is teaching and discussion based and the other ½ is role play and skill practice. There are 20 people per class, who commit to 10 sessions at 2.5 hours each. Historically, these trainings have taken place in person but switched to Zoom due to the COVID-19 pandemic.

In 2020, they released an entirely new curriculum after having undergone a three-year rewrite process. The rewrite was complete before the COVID-19 pandemic, but primarily focused on new sections on technology and communication.

The initial training of listeners takes place before they are assigned a care receiver. Continuing education takes place after they finish the training and throughout their time in serving as a Stephen Listener. The initial training covers essential topics such as the art of listening, maintaining boundaries in caregiving, crisis theory and practice, confidentiality, grief, depression, distinguishing feelings, using mental health professionals and other community resources, and supervision. Continuing education opportunities are provided by the national Stephen Ministry organization and include serving those who are dying and their families and friends, caring for those experiencing a major medical crisis, aging, or needing long-term care, and caring for those experiencing a divorce.

The Peer Listeners

Stephen Leaders are responsible for recruitment of Stephen Listeners. Stephen Listeners undergo 25 hours of training. Stephen Leaders are responsible for supervision of listeners. Stephen Leaders do a week long training to serve as a Stephen Leader, which includes 40 hours of training.

When someone applies to receive care or be listened to, that person is first interviewed by a leader to make sure it's not something beyond a listener's capacity. During training for Stephen Leaders, there are sessions on how to find care receivers and mental health concerns with Stephen Listeners. They have a textbook of when and how to use mental health resources and how to make referrals. Examples of issues that would get a mental health referral would be active substance abuse or untreated mental illness. Stephen Ministry also does not serve minors because there can be no guarantee of confidentiality.

Supervision Best Practices

The group should meet two times per month for a minimum of one hour. The ideal situation is that every person that has an active care receiver has a chance to "be in the spotlight" every 6-8 weeks to process their current accompaniment work in a more in-depth fashion. In essence, every meeting everyone gets to share but every 6-8 weeks one listener gets to share, process, receive feedback, and ask questions for 30-40 minutes.

Program Data

Stephen Ministry does not currently have the staff capacity for long-term data tracking or analysis. The primary data available is about the number of partner organizations and the number of people who have been trained as Leaders or Listeners.

Considerations in Adopting or Adapting from this Program

The Stephen Ministry program is an explicitly faith-based program and one that does not provide disaster specific training to its members. Stephen Ministry trains Stephen Leaders, who commit to serving in that capacity for a minimum of two years. They are often paid staff within an institution. They can provide guidance, evaluation, and feedback to the national organization. Stephen Leaders train Stephen Listeners, who also commit to two years of participation, but often serve much longer. They believe 40 hours of training with resources is the minimum for someone acting in a Stephen Leader or similar capacity. We

have included in the materials provided through this project a typical Stephen Leader Training Course, which outlines the 40 hours of training required for Stephen Leaders.

Resources Shared

1. Stephen Ministry Leader’s Training Course Sample Agenda
2. The Joplin Globe, Stephen Ministers Helping People Get Back On Track, 2012
3. Stephen Ministry FAQs

Interview

3/02/22, 55 minutes, Bianca Vazquez with Laurie Kem, Stephen Ministry Staff

University of Michigan's, Ann Arbor HS/MS Peer-to-Peer Program

In 2007, the Eisenberg Family Depression Center and the Ann Arbor Public Schools (AAPS) began a collaboration to provide depression awareness and suicide prevention education, training, and support for AAPS personnel. Beginning in fall 2009, a student education component, called the Peer-to-Peer (P2P) program, was added to this initiative. The P2P program was built on the premise that many mental health disorders first present themselves during adolescence and teens are more likely to listen to other teens than well-meaning adults.

Highlights

Year Founded	# Listeners	Hours of Training	# of People Served in Year
2007	400-500/year	Initial: 8-hour training Ongoing: N/A	50,000 since 2007

Best Practices

- *Clear and consistent community partners.* The Peer-to-Peer program partners with 30 high schools and middle schools in Washtenaw County. They have built long standing partnerships with school administrators, counselors, teachers, and students over the past 15 years.
- *Knowing when to refer and having a referral plan*: Each of the 500 students who are trained receive 8 hours of training, a large portion which includes when to make a referral. The P2P program partners with school counselors and the University of Michigan's TRAILS program to provide CBT therapy to students.
- *Sticking to core messages*: The P2P program allows students to create campaigns to break down mental health stigmas and make seeking mental health support more accessible and less scary. Each student team creates consistent campaign messages throughout the year that are built on core messages.

Program Design

In 2007, the Eisenberg Family Depression Center began providing depression awareness and suicide prevention education, training, and support to staff in the Ann Arbor public schools. They found that while teaching these tools to staff was essential and effective, young people are more likely to listen to their peers than to adults. In 2009, the collaboration launched the Peer-to-Peer program.

The Peer-to-Peer program (P2P) partners with 30 high school and middle schools throughout all of Washtenaw County. Each school has a team of 10-20 students who receive training on the signs and symptoms of mental health (depression and anxiety), substance abuse, sleep, and self esteem. They then design campaigns throughout the year to destigmatize and normalize asking for support when needed.

Each school group is staffed by one of four staff members who work for the P2P program. At least once a year each school holds an all school assembly where the P2P team presents their campaigns and generates safe ways for students to ask for support anonymously.

The P2P program has strong and clear relationships with each school's counseling offices and with the University of Michigan's TRAILS program which provides therapy onsite to the schools. Students nor P2P staff provide therapy or any mental health services to their peers.

Curriculum

The training for the P2P program is an 8-hour training session. The pedagogy for the training is 75% didactic (mostly presentations). Training topics include the following: signs and symptoms of mental health (specifically depression and anxiety and what they look like in the real world), substance abuse, sleep, and self esteem. Along with identifying mental health struggles as they arise, the curriculum also gives the students information about therapy and stress relief models such as Cognitive Behavioral Therapy, yoga, and movement activities.

Once the students have a clear sense of behavioral health struggles and potential resources, they create messaging and campaigns to educate the student body at their school about mental health awareness. Each of these campaigns are listed online along with their presentations at the following: https://www.depressioncenter.org/p2p

The Peer Listeners

There are 400-500 Peer Listeners across 30 schools each year through the P2P program. These are all students who work in teams of 10-20. Their primary role is to create awareness campaigns, identify students who may be struggling with mental health concerns, and create safe ways to make referrals for additional support. Each team is allotted a budget of $300-400 per year which they use to purchase stickers and other promotional materials for their campaigns. Each listener is well trained and well versed in

making effective referrals to trained professionals that have been put in contact with at each school.

Supervision Best Practices

The peer listeners receive an initial training at the beginning of the year and then continue to meet on an ongoing basis. They are supported by a team of four P2P program staff, most of whom have master's level training in social work, psychology, and public health. The team of four staff is split between 30 schools. In addition to the P2P staff, each school works with teachers and mentors who are staff at school sites.

Program Data

Each academic year, the P2P program assesses their impact through pre- and post-intervention questionnaires. There are consistently positive results among both the P2P student members and the student population at large. Findings from the P2P program suggest that it increases mental health literacy and encourages youth to turn stigma surrounding mental health challenges into compassion, so they are not only aware of available resources, but also feel comfortable getting the support they need and encouraging fellow students to do the same. The P2P program is considering collecting more specific data that would allow them to measure individual impact more fully as well as scope. They are studying ways to collect this data anonymously and ethically.

Considerations in Adopting or Adapting from this Program

The University of Michigan Peer-to-Peer program seeks to shift cultural norms and practices around mental health stigmas. This is done using a youth leadership approach using campaign development and youth to youth referral systems. This program does not train youth to be peer mediators or to do counseling directly. It is primarily a referral model. The P2P program has worked with one school, Huron High School, which created a peer mediation model. This school has a separate training that is one year long where students were trained to do mediation and counseling directly. This school has a counseling center placed directly next to the space where students doing peer listening should they need additional support from trained professionals. The P2P model has a large reach and remains clear in what role they play while making calculated referrals where needed.

Resources Shared

1. Peer to Peer Mentoring Manual
2. Peer to Peer project proposal template

3. Videos and media to use in classroom presentations (potentially useful media around mental health topics)

Interview

3/18/22, 60 minutes, Maureen Okasinski & Meghan Sobocienski with Stephanie Salazar, Director, University of Michigan Peer-to-Peer Program

Red Hook Initiative, Local Leaders Program

The year after Hurricane Sandy decimated the Brooklyn neighborhood of Red Hook, the Local Leaders program was launched in July 2014. The new training series brought Red Hook residents together to improve individual and family preparedness and to strengthen social resiliency of public housing residents. Local Leaders meet once a week for two-hour sessions over the course of 10 weeks.

Highlights

Year Founded	# Listeners	Hours of Training	# of People Served in Year
2014	200	Initial: 20	Data not available

Best Practices as Recommended by the Organization

- *Combine community organizing, mental health first aid, and disaster preparedness:* This unique training equips local leaders to act in the immediate aftermath of a disaster, especially because in the case of a major disaster it may be days or weeks before government assistance arrives.
- *Cultivate a cohort:* It is necessary to create relationships between listeners.
- *Stipend:* For low-income training participants, a stipend may be necessary to ensure people can participate and take time off of work.
- *Utilize local leaders to shape curriculum:* Over 60% of training participants have lived in Red Hook, Brooklyn for more than 20 years. They were an integral part in shaping the curriculum over multiple evaluative iterations.

Program Scope

Red Hook, Brooklyn, a community where close to 70% of residents live in public housing, was one of the most affected neighborhoods by Hurricane Sandy. Red Hook is surrounded on three sides by water. Furthermore, many areas along the waterfront were historically marshland, leaving the community susceptible to flooding. RHI's immediate crisis response and recovery efforts, led by Red Hook residents, volunteers and staff, taught the importance of community-led response to emergencies and the importance of social networks among neighbors in times of crisis.

In 2014, Red Hook Initiative (RHI) launched "Local Leaders," a training program designed for public housing residents to learn about emergency preparedness and community organizing. This program was developed through lessons learned in response to Hurricane Sandy. The new training series brought Red Hook residents together to improve individual and family preparedness and to strengthen social resiliency of public housing residents. Local Leaders meet once a week for two-hour sessions over the course of 10 weeks. Participants are compensated for their investment of time and dedication over 10 weeks with a stipend.

Local Leaders learn skills in how to prepare themselves, their family, and the community for emergencies and how to respond if an emergency occurs. In addition to preparedness skills, Local Leaders learn principles of community organizing, mediation, and self-defense, and earn certifications in CPR and basic first aid. The responding to mental health emergencies section covers emotional first aid and how to provide effective support during a crisis.

Curriculum

RHI's immediate crisis response and recovery efforts, led by Red Hook residents, volunteers, and staff, highlighted the power of community-led response to emergencies and the importance of social networks among neighbors in times of crisis. The coordinators and facilitators of the local leaders program were community organizers and social workers, in conjunction with the local Emergency Management Office.

The curriculum was based on the real life experience of neighborhood leaders after the storm. This was a major strength of the curriculum, along with developing local leaders to be prepared to act in the aftermath of a storm. RHI completed regular surveys and focus groups to discern what people thought was important to know. Initially the curriculum focused on community building and recovery work, including classic emergency preparedness (how to pack a go bag) and culturally relevant readiness plans. RHI also taught practical organizing skills like door knocking and phone trees. RHI own social workers facilitated the sessions on mental health first aid.

A limitation of the curriculum is that as RHI and the Local Leaders Program gets further from the initial disaster, it has been difficult to maintain focus on disaster preparedness and response. The local leaders training focuses on organizing around the housing authority and public housing.

Training topics include: individual and family emergency preparedness planning, conflict resolution and mediation, responding to mental health emergencies, community organizing, political education, climate justice, CPR & first aid, heat emergencies, self-defense and bystander intervention, and planning projects in the neighborhood.

The Peer Listeners

Community leaders who were already connected to RHI in some way, but essentially it was by word of mouth. The leaders who were trained are 78% female, 96% Black or Latino, and have an event split between primary English and Spanish speakers. Most have lived in Red Hook for over 20 years.

Program Data

Residents are united, more connected with neighbors and to community resources. Over 90% of respondents agree that they have stronger relationships with neighbors after completing the Local Leaders training. In a post training survey, over 3/4 of residents respond that after completing the class they have more knowledge of resources in Red Hook that can be of support to them. Local Leaders expressed an increased sense of hope and responsibility for Red Hook's future. Over 95% of respondents report that they are capable of helping their neighbors in a future emergency. After completing the Local Leaders program, 95% of respondents consistently reported that they are more prepared for emergencies than before the class.

Considerations in Adopting or Adapting from this Program

In response to the COVID-19 pandemic, and the lack of digital access, RHI has done extensive tablet and WiFi hotspot distribution. There has also been extensive outreach around digital literacy and getting residents acclimated to using Zoom. RHI hosts regular calls and open meeting rooms for neighbors to connect with one another.

Resources Shared or Available

1. Local Leaders Curriculum - 2015
2. Local Leaders Curriculum - 2016
3. Local Leaders Curriculum - 2017
4. Local Leaders, A Community Based Response To Crisis

Interview

3/22/22, 45 minutes, Catherine McBride, Director of Community Building, interviewed by Bianca Vazquez

Crisis Emotional Care Team, Vibrant

The Crisis Emotional Care Team (CECT) at Vibrant provides just-in-time support and care for those in the acute as well as longer-term recovery phases of a natural or human-caused disaster or crisis. CECT is a team of volunteer emotional care providers committed to effectively and intentionally alleviating emotional suffering in the wake of disaster or crises.

Highlights

Year Founded	# Listeners	Hours of Training	# of People Served in Year
2019	600+	Volunteers have mental health credentials and are pre-trained.	350; 1000 in 3 years

Best Practices as Recommended by the Organization

- *Build a network of professional listeners:* Vibrant has a substantial list of 600+ volunteers who are trained mental health and wellness professionals. These include disaster response workers, social workers, therapists, and psychiatrists.
- *Networking of listeners:* Volunteer listeners are gathered for formal and informal gatherings on a quarterly basis. They also network with other Vibrant care teams within their network regularly and share their structure and model widely.
- *Formalize process and structure:* Vibrant has a set structure for intake when people are experiencing crisis as well as a set structure for gathering professional volunteers as listeners and investing in networking them as a team.

Program Design

Vibrant Crisis Emotional Care Team delivers crisis intervention and emotional care to empower survivors to navigate, process, and work through the distress of a disaster. The CECT also offers training to local providers in an effort to build their capacity to carry services through the longer-term recovery process. They define crisis broadly but are prepared to respond to the following: natural or human-caused disasters, emergencies that cause major disruption of individual or community functioning, community violence, death of a staff member or program participant, cluster suicides, and school suicides. Founded in 2019, the majority of the program's life has existed virtually, providing resources through Zoom and similar platforms.

Individuals and organizations in need of support in the wake of a distress or disaster can contact the CECT through an online intake form. A specialist will reach out to these individuals and organizations to provide an intake interview and deploy the best suited volunteers for each situation. Vibrant recruits professional disaster care workers, social workers, psychiatrists, therapists, and counselors from local communities via word of mouth and through an online form on their website. They then link professional listeners with those seeking support.

Over the course of the year, the CECT brings together their cohort of 600+ professional volunteers to meet together, share best practices, and celebrate the work they have done together.

The Peer Listeners

Vibrant Crisis Emotional Care Team gathers large teams of professionally trained community listeners. In the three years they have existed, they have gathered a team of 600+ volunteers. They have a link on their website to gather volunteers: https://cectvolunteers.force.com/s/interest

Volunteers go through an initial training and there is a peer training curriculum that is used by the advisory board at Vibrant. The vast majority of the listeners are trained professionals and hold mental health credentials so the focus of the listeners is more on connecting people needing support to providers rather than training people who are not mental health professionals as listeners.

Program Data

The organization has done some initial data collection in its first 3 years of existence. They track the number of requests made for support, the number of contacts made, and the number of volunteers willing to provide support to people seeking it. There does not seem to be significant post-connection outcome data collected.

Considerations in Adopting or Adapting from this Program

This program began right before the COVID-19 pandemic and was designed primarily during the pandemic, online and virtual. The CECT has a large reach of people requesting support and previously trained volunteers who are willing to dedicate time to supporting people experiencing crisis. As much as the CEC team has been able to expand and grow, there is still a huge need for more listeners, and more services. The team receives far more requests for services then they have volunteers to fill.

This program has a wide reach and impact, though is not actively engaged in training non-professional listeners rooted in communities. There is a training curriculum which is underutilized and could potentially expand the CECT's reach.

Resources Shared

1. Intake form for individual or organizations requesting support:
    - https://cectvolunteers.force.com/s/supportrequest
2. Volunteer listener/responder interest form
    - https://cectvolunteers.force.com/s/interest

Interview

3/10/22, 45 minutes Raven Blue, Program Director Vibrant Crisis Emotional Care Team, by Meghan Sobocienski

Mississippi-Alabama Sea Grant Consortium Peer Listening Program

When a fishing boat captain committed suicide 45 days after the BP Deepwater Horizon oil spill, MS-AL Sea Grant initiated their Peer Listening Program to respond to mental health needs of communities. The program enlisted Dr. J. Steven Picou who developed the Prince William Sound Regional Citizens' Advisory Council's Peer Listening Program.

Highlights

Year Founded	# Listeners	Hours of Training	# of People Served in Year
2010	163 2020/21 online 7,645 in person 2010/11	Initial: 4 hours Ongoing: 0	Not recorded

Best Practices as Recommended by the Organization

- *Active and cooperative learning:* People zoned out when listening to didactic content. For training to be effective, people need to be active, need to connect to things with which they are familiar. Small group interactions give greater comfort and more space for questions and deeper reflection.
- *Cohort model:* You need a cohort, peer listeners need a support network and supervision. Peer listeners will have their own mental health needs to be attended to along with their interest in supporting others. People who are already overtaxed are being asked to do more. They cannot do this work alone, not if they are going to do it well.
- *Peer listening as a necessity:* Mental health service providers in our area are at or near capacity. We have compounding disasters in our area: the hurricanes, severe storms, oil spill, economic downturn, and COVID. The allostatic load of people to be able to bounce back or come back to a new normal has just decreased because there have been so many disasters. Peer listening can shine in responding to feelings of mistrust and uncertainty, to questions, blaming, and mistrust of information because it builds from established social networks.

- *Build a network of listeners:* All the issues across our country, whether it's a technical disaster, natural disaster, uncertainty and mistrust, we need to build networks of listeners and it's going to become more and more essential.

Program Design

MS-AL Sea Grant provides training for peer listening across the two states as well as on request in other communities experiencing natural and technological disasters. The program has continuously evolved since its origin to respond to tornadoes, hurricanes, and other disasters, and to partner with mental health professionals in design and delivery. When the COVID-19 pandemic began, the program delivery ramped up and moved online. MS-AL Sea Grant staff determined it needed the expertise of mental health professionals to respond to questions particular to mental health. Coastal Family Health has been an important partner in delivering training, connecting to community members who attend the training, and in doing community outreach on disaster and mental health needs. The program is deployed in response to disasters and therefore varies in frequency of delivery.

Training is intended for people to apply with other people in their social and/or professional network (e.g., a hairdresser talking to customers, firefighters talking to each other about the stress they are experiencing, talking to a neighbor or friend). The program does not define parameters for how often or how long to talk with someone as it is intended to enhance the listening skills with those with whom they are already in community. There is no expectation of an ongoing relationship or reporting at the organization where people attended the Peer Listening training. The curriculum includes a module on providing support and listening for phrases that should trigger a referral for mental health services including statements about self harm.

Curriculum

The first curriculum was developed by Dr. J. Steven Picou and informed by the PWSRCAC's Peer Listening program. By the next round of updates, the organization recognized the importance of partnering with mental health service providers in design and delivery so that someone with that expertise was a part of the training. The COVID-19 pandemic led to another round of revision in which the training curriculum became an online recording that could be accessed through their website and YouTube and the training manual was revised to include more scenarios and activities. Multiple people helped with that process. The length of the training and the online modules made it possible for more people to access the training which was especially important with the magnitude of the need as well as the opportunity for individuals to access and complete it at their own pace.

The current curriculum includes two 2-hour, online training modules and an 82-page training handbook.

The topics covered include types of disasters and the effect of technological disasters on communities, the definition and value of peer listening, tips for providing peer support, common symptoms, and how to recognize and provide referrals for additional services. According to the staff, the revised curriculum added more focus on role playing and personal reflection on impact.

The Peer Listeners

After the BP Deepwater Horizon oil spill (between July 2010 and July 2011), 7,645 people were trained. MS-AL Sea Grant did this directly with about 400 and the remainder were done by Coastal Family Health Services. During the COVID-19 pandemic, 163 people completed the training.

Because the program director has a broad role within MS-AL Sea Grant and interacts with many different municipal and local organizations, she is able to spread word about the availability of the program and hears other entities describe the need for peer listeners in their organization or community.

While no data on the demographics of those who attend training is kept, the organization sees a deep variety of people, from students to veterans, in attendance.

Once training is completed, there is no expectation of supervision, ongoing support, or relationship between the organization that sponsored the training and the participants, or with Mississippi-Alabama Sea Grant. They did create an online community where people could log in and ask questions of other peer listeners. However, it was not particularly active and due to lack of resources the organization was unable to evaluate why.

Program Evaluation

The organization did some initial data collection after Deepwater Horizon spill, such as asking peer listeners how many hours they spent and issues on which they spoke but did not continue to do so in subsequent years. People who attend training are invited to take a survey at the end of the training as part of evaluation on the quality of the training. All data is kept anonymous or confidential. There is a concern about the politics of evaluation because the Sea Grant staff have ongoing relationships with many communities and do not

want to ask or hold data that could be sensitive. Once, Dr. Picou was subpoenaed to find out who was seeking peer listener support.

Considerations in Adopting or Adapting from this Program

The program was born of necessity and responds to crisis. As such it has not engaged in reflection to the extent that they would like to in regard to strategic planning or moving beyond responding/reacting. They would like to get to a point where we could thoughtfully look at what this looks like on a spectrum for listeners and people who would like to have more mental health services in these fields. Ideally, there would be funding for a full-time person on this project and it might become more integrated into the rest of the programming they do. Noting the necessity and value of each, the program would investigate more the overlay of virtual with in-person instruction.

Resources Shared

1. Online 4 module training curricula: https://masgc.org/peer-listening/training
2. Online training manual

Interview

3/24/22, 60 minutes Steve Sempier, Outreach & Deputy Director, and Tracie Sempier, Coastal Resilience Engagement Specialist, by Bianca Vazquez and Maureen Okasinski

University of Michigan CAPS (Counseling and Psychological Services) Peer Counseling Program

The Peer Counseling program launched in January of 2021, partly prompted by the COVID-19 pandemic and building from years of interest by students in this particular service. Peer support at the organization goes back to the late 1980s when CAPS had a phone support line and peer support availability on the campus includes a student group, the Wolverine Peer Support Network, that provides group-based peer support. The intention in selection of the name Peer Counseling was to make a clear connection to CAPS.

Best Practices

- *Formal request process for services*: The use of the request form by students seeking peer support
- *Public bios of peer counselors:* The inclusion of peer counselors' bios on the home page to provide information so that those seeking support can make an informed choice.
- *Representative diversity of peer counselors:* Having diversity of peer counselors including gender, identity, and language spoken may be the reason that our peer counselors talk to groups that are normally underrepresented in access to mental health services and come from marginalized identities. In the CAPS program, the number one request is for African American women.

Highlights

Year Founded	# Listeners	Hours of Training	# of People Served in Year
2021	15	*Initial:* 10 hours *Ongoing:* 1-hour weekly meetings/training	147+ (21/22 academic year)

Program Scope

Trained student peer counselors, under the supervision of a licensed Master of Social Work (MSW) individual, serve as active listeners for other students to talk about areas of their life in which they are experiencing stress or struggle. UM students learn about the availability of the peer counselors through the CAPS website (the front page), their weekly residence

hall newsletter, or through word of mouth from other students–usually those who are interested in mental health and wellness. Interested students complete an online form (see additional resources available through PWSRCAC) requesting to meet with a peer counselor and identifying their general areas of concern. The student can read the peer counselors bios and request a particular counselor. About 75% of students do not state a preference. While there is no limit to the number of sessions or the frequency of sessions, most students have 1-2 sessions with a peer counselor, for those who have more than two sessions, most are 3-5 sessions. A small handful have met more than five times.

Students come to peer counselors to talk about feelings of loneliness, identity, and social relationships/anxiety. Students are often exploring whether they want or need formal counseling. A small number have continued to talk with their peer counselor while seeing a counselor at CAPS. Peer counselors refer students for additional mental health services when the issues of sexualized violence, trauma, and suicide are present. Peer counselors are not trained to professionally assess risk. Both on the student request form and on the peer counselors' contract the inability of peer counselors to respond to urgent and crisis requests is made clear. Because the peer counselors are often a bridge to more formal services, the weekly meetings also ensure that they have the most up to date info on the professional services at CAPS, including wait times and communicate that with students. Note: Most wait time for professional services is between the initial consultation (which is within 1-3 days) and the first session. When someone is in urgent need, CAPS has same day services and 24/7 phone support.

Peer counselors can meet with other students at any time virtually. When they meet in person, it is at the CAPS offices with a CAPS staff in the building. Meeting in person in any other setting is not allowed.

Peer counselors are volunteers and sign an agreement that lists rules about the program such as the prohibition about socializing with the person. They are required to attend one hour each week of supervision and the minimum commitment is two hours a week. They can determine if they are full and cannot take on new people. They currently have a good match between requests for services and the number of peer counselors. Of the current 15, 11 have said they are full and/or only taking new people who specifically request them. Each peer counselor generally works with 2-3 students at a time.

After the initial recruitment and training at the beginning of the academic year, the program supervisor devotes about 3-4 hours each week to the program. Other experts

contribute to training. In total, 8-10% of the supervisor's time is devoted to the program in the initial part of each year.

Curriculum

Peer counselors complete 10 hours of group training before they can meet with students. Active listening is covered in two hours. There is a 90-minutes segment on suicide gatekeeping, one hour on multicultural considerations, and one hour on sexualized violence & trauma, and alcohol. The training includes orientation to the program, their role and responsibilities, how to complete documentation, recognizing crisis and urgent support needs, and when to refer to CAPS. The direct access to CAPS services and of the peer counselors to trained and practicing counselors with a range of specializations contributes to the understanding and development of the peer counselors. One growing edge of the curriculum is to incorporate more ongoing role play and in weekly group meetings increase the involvement of other colleagues to help with the supervision and debriefing sessions with the peer counselors.

The Peer Listeners

The first cohort of peer counselors started in September 2020. The CAPS staff reached out to three different student organizations with mental health/well-being focus to recruit this first cohort. The first cohort was 16 people, seven of whom graduated and eight who continued in fall 2021. They recruited a second cohort in fall 2021 that was open to anyone and shared on their website. The second cohort began with eight peer counselors and one decided to leave the program. Current total is 15 peer listeners. Nearly all were undergraduate students including freshmen and there was one graduate student. Their areas of study at UM are most often associated with mental health such as psychology. The program wants to have students from a range of study areas, particularly would like more from engineering, and works with the liaison network across colleges on campus to discuss need and recruit broadly. Beyond the college the student attends, the peer counselors have a range of identities and some are bilingual.

A licensed MSW meets with the peer counselors for 45-60 minutes each week. The group is divided into two smaller groups. About ⅔ of the sessions are the week’s announcements, logistics, requests for matches, getting peer counselors involved in project parts of the program like designing a logo or an interest form, questions/concerns/experiences having with students that you’re talking to, and how to support someone they are talking to. The other ⅓ of the meetings have other CAPS staff come in and do ongoing education sessions for the peer counselors in topics such as motivational interviewing, eating issues, and

sports psychology. Because students are interested in this as a career they have people come with varied degrees and career track ideas to give them some ideas. This happens 3-4 times a year.

Program Evaluation

The program has the data from the interest forms that students fill out initially.

Considerations in Adopting or Adapting from this Program

Three additional areas of development were cited by the staff. 1) Include more role playing and active learning in training the peer counselors, 2) doing more data collection, 3) more attention to the peer counselors' well-being. That would include more conversations with the peer counselors about their own struggles, paying attention to see if they need to stop meeting with other students, and talking with them about how they are able to support other people when they themselves also struggle.

Resources Shared

1) Interest form-filled out by person seeking peer counseling
2) Training curriculum outline
3) Peer counselor contract

Interview

3/24/22, 60 minutes, Edward Huebner, MSW Assistant Director, interviewed by Maureen Okasinski

Appendix D: Stakeholder Interview Questions

1. Can you share your affiliation and role at PWSRCAC?
2. What has been your involvement with the Peer Listener Program?
3. Participated in the training? *[*if no*, skip to #4] *If yes,* have you used the peer listener skills?
    a. *If no, didn't use the skills,* What affected this?
    b. *If yes,* How did you use what you learned in the program? (for example - in a structured way, or as general life skills)
        i. Could you tell me more about how recently you did this? Who you talked to and how many? What were some concerns they shared?
        ii. What kind of obstacles did you encounter? [notice statements about being in over their head, needing support, unsure of how to go about doing this, confusion about your role, boundaries, ethical considerations]
    c. What was most valuable to you in the training?
4. From your vantage point, where were the successes of the Peer Listener Program? What were the limitations? [make sure to note/modify the question awareness that some people have not participated in training, and note their dual roles as participants and Board members]
    a. *If yes OR no,* What changes to the program would make it more likely for you to use it in the future?
5. We are also interviewing staff from other peer listening programs in other parts of the country. As we compare PWSRCAC's program to these, what would you want us to keep in mind about the unique needs of the Exxon Valdez oil spill region?
6. *Outcome frame //* What would happen post disaster with a high-quality, successful Peer Listener Program in place? [ask questions to probe and clarify broad responses]

a. What would be happening pre-disaster with the Peer Listener Program for that to be true?

b. If those happened, would you be interested in being a peer listener?

i. If not, what would it take?

7. *Scope question //* If we were not considering budget or organizational capacity, what would you like to see the program do? [What would your ideal configuration be (examples could be - a team of trained professionals for deployment, an ongoing program where a trained professional in a community serves as lead to a team of listeners, etc.)]

   a. Share some examples

8. *Thematic question //* *As an individual and a leader, what would be the most valuable training that would make a difference in your life and your community ahead of and/or responding to a disaster?

   a. Outside of training, what knowledge, topics or resources would be most valuable for you to be able to access or activate in responding to a disaster? [this may have already been answered in a prior question such as #6]

9. Why does the Peer Listener Program matter?

   a. How does it fit into the larger organization? (or community)

   b. What is your expectation of PWSRCAC in supporting this program? [take note of suggestions that imply expansion]

   c. What would it look like for community support to grow?

10. Is there anything else you'd like us to know?

Appendix E: Key Recommendations for Peer Support Programs

From: Creamer, Mark C. et al. (2012). "Guidelines for Peer Support in High-Risk Organizations: An International Consensus Study Using the Delphi Method." Journal of Traumatic Stress, 2012, 25, 134–141.

Eight key domains of recommendations emerged from the project findings. A starting point for these recommendations is the consensus view that all high-risk industries should have a well planned, integrated, and tailored peer support program for their current employees, as well as, for a limited time, once employment with the organization ceases. Each context, however, is different. The following recommendations should not be interpreted rigidly but, rather, should be implemented as appropriate to the specific context of the program. This is particularly important since there is currently an absence of objective empirical evidence for the effectiveness of peer support in improving psychosocial outcomes. Indeed, the authors strongly support the establishment of properly designed and controlled research trials to inform our understanding of the effectiveness of these models.

1. The Goals of Peer Support: Peer supporters should:
   (a)provide an empathetic, listening ear;
   (b) provide low level psychological intervention;
   (c) identify colleagues who may be at risk to themselves or others; and
   (d) facilitate pathways to professional help.

2. Selection of Peer Supporters: In order to become a peer supporter, the individual should:
   (a) be a member of the target population,
   (b) be someone with considerable experience within the field of work of the target population,
   (c) be respected by his/her peers (colleagues), and
   (d) undergo an application and selection process prior to appointment that should include interview by a suitably constituted panel.

3. Training and Accreditation: Peer supporters should:
   (a) be trained in basic skills to fulfill their role (such as listening skills, psychological first aid, information about referral options);

(b) meet specific standards in that training before commencing their role; and (c) participate in on-going training, supervision, review, and accreditation.

4. Mental Health Professionals: Mental health professionals should:
   (a) occupy the position of clinical director, and
   (b) be involved in supervision and training.

5. Role: Peer supporters should:
   (a) not limit their activities to high-risk incidents but, rather, should also be part of routine employee health and welfare;
   (b) not generally see “clients” on an ongoing basis but should seek specialist advice and offer referral pathways for more complex cases; and
   (c) maintain confidentiality (except when seeking advice from a mental health professional and/or in cases of risk of harm to self or others).

6. Access to peer supporters: Peer supporters should normally be offered as the initial point of contact after exposure to a high-risk incident unless the employee requests otherwise. In other situations, employees should be able to self-select their peer supporter from a pool of accredited supporters.

7. Looking after peer supporters: In recognition of the potential demands of the work, peer supporters should:
   (a)not be available on call 24 hours per day,
   (b) be easily able to access care for themselves from a mental health practitioner if required,
   (c) be easily able to access expert advice from a clinician, and
   (d) engage in regular peer supervision within the program.

8. Program evaluation: Peer support programs should establish clear goals that are linked to specific outcomes prior to commencement. They should be evaluated by an external, independent evaluator on a regular basis and the evaluation should include qualitative and quantitative feedback from users. Objective indicators such as absenteeism, turnover, work performance, and staff morale, while not primary goals of peer support programs, may be collected as adjunctive data as part of the evaluation.

Not specifically addressed in the consensus statements (although strongly implied) is the need for rapid access to appropriate mental health services delivering evidence based

treatment for those who require it. It is incumbent upon organizations to ensure that these pathways and services exist.

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