Evaluation of the Peer Support Certification Training Program
Depression and Bipolar Support Alliance
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Introduction

The Peer-to-Peer Resource Center's (PPRC) pilot Peer Specialist training took place at the Holiday Inn Select in Decatur, Georgia, over the week of June 20-25, 2004. The pilot training involved the delivery of a 30-module draft Peer Specialist curriculum to prepare consumers to work with their peers on self-directed recovery and employment, with the ultimate goal of a meaningful life in the community for all participants. Forty-one consumers from 14 states took part in 30 hours of training over six days. The PPRC funded all trainee expenses, including travel to/from the training site, hotel accommodations, and meals.

Recruitment and selection

Trainees included consumers affiliated with chapters of the Depression and Bipolar Support Alliance (DBSA), and other experts in the field of peer support and peer specialist training. A majority of trainees applied to participate by completing an application that was reviewed and rated by PPRC staff. Trainees were recruited primarily from six states in diverse regions of the country (FL, GA, NJ, OH, OK, and TX). Fifty applications were received from individuals in these states, and 42 participants were selected. Of the 42 total participants invited to participate in the training, 41 actually took part (three were partial attendees).

Curriculum development and content

The training curriculum was developed by the PPRC after a review of peer specialist training materials and curricula from around the United States. PPRC staff was assisted by outside consultants under a contract with the Appalachian Consulting Group. Training materials, resources, curricula, and exercises used in development of the training curriculum included:

1. *Boston University Certificate Program in Psychiatric Vocational Rehabilitation Training*
2. *C.E.L.T. Leadership Academy Training/MHA of Virginia*
3. *Georgia Peer Specialist Training*
4. *META Services Peer Support Specialists Training*
5. *NYAPRS Peer Bridger Program Training*
6. *U. S. Psychiatric Rehabilitation Association (USPRA), formerly IAPSRS*
7. *Wellness Recovery Action Plan, developed by Mary Ellen Copeland*
8. *Wellness Recovery Action Plan and Peer Support, by Mary Ellen Copeland and Shery Mead*

Prior to delivery of the training, the draft curriculum was reviewed by eight individuals* who have expertise in recovery and peer specialist initiatives, and training content and materials were then adjusted in response to their input. Following incorporation of the results of the training evaluation described in this report, a new draft of the curriculum will be revised, re-reviewed and approved by the Center for Mental Health Services (CMHS). This curriculum will then be made widely available throughout the country under the terms of the center's agreement with CMHS.

* *Pre-training curriculum reviewers:* Peter Ashenden, Celia Brown, Mary Ellen Copeland, Vicki Cousins, Edward Knight, Shery Mead, Kathy Muscari, and Melody Riefer

Training overview

- *Sunday, June 20* – The group was welcomed by Lisa Goodale of the PPRC, who reviewed the training process and schedule for the week ahead. After group introductions, the first two training modules were delivered. These modules presented information on current evidence based practices and policy issues. The modules were: Evidence Based Practices & the President's New Freedom Commission Report on Mental Health; and The Role of Peer Support in the Recovery Process. Training adjourned at 4:30 p.m.
- *Monday, June 21* – During this full day of training (8:30 a.m. – 4:30 p.m.) – six modules were delivered. These modules focused on recovery values and beliefs, and included: Values and Beliefs Supporting the Recovery Process; Is Recovery Really Possible? & How Negative Messages are Sent; The Power of Negative Messages & Creating Recovery Environments; Psychosocial Rehabilitation as the Road to Recovery; Mental Illness Diagnoses; and Reclaiming Your Power During Medication Appointments.
- *Tuesday, June 22* – This full day of training (8:30 a.m. – 4:30 p.m.) – included six modules. These modules focused on communication and goal setting, and included: The Impact of Diagnosis on One's Self-Image; Effective Listening and the Art of Asking Questions; Facilitating Recovery Dialogues; Dissatisfaction as an Avenue for Change; Ten Steps to Creating the Life You Want; and Facing Your Fears. Trainees were offered an additional opportunity to meet with a representative of the local Double Trouble in Recovery organization during the evening.
- *Wednesday, June 23* – This full day of training (8:30 a.m. – 4:30 p.m.) – also involved the delivery of six modules. These modules included a focus on models of individual and group interactions: Combating Negative Self-Talk; Problem Solving with Individuals; Cultural Competency; Overview of Peer Specialist Models; Power, Conflict and Integrity in the Workplace; and Spirituality and Recovery.
- *Thursday, June 24* – This full day of training (8:30 a.m. – 4:30 p.m.) – involved six modules. These modules focused on evidence based practices and employment, including: Supported Employment as an Evidence-Based Practice; Supported Employment and Federal Work Incentives – Part 1; Supported Employment and Federal Work Incentives – Part 2; The Role of Employment in the Recovery Process; Supported Employment and Peer Support Groups; and Creating Your Wellness Recovery Action Plan (WRAP).
- *Friday, June 25* – Training began at 8:30 a.m. and concluded with the final two modules, which were: Employment Wellness Recovery Action Plan (EWRAP); and Review of

Training, Revisiting of Values and the Testing Process. These were followed by an hour of information on next steps, including the upcoming testing of knowledge, and completing an overall evaluation of the training. Training concluded with an informal lunch and celebration at 12:30 p.m.

Trainers

The following individuals served as trainers:

- Sally Atwell, Shepherd Center
- Mark Baker, Appalachian Consulting Group
- Sue Bergeson, Peer-to-Peer Resource Center
- Linda Buckner, Appalachian Consulting Group and the GA Mental Health Consumer Network
- Ellery Farrell, Appalachian Consulting Group
- Beth Filson, Appalachian Consulting Group
- Larry Fricks, Appalachian Consulting Group and Office of Consumer Relations, GA Division of Mental Health, Developmental Disabilities and Addictive Diseases
- Lisa Goodale, Peer-to-Peer Resource Center
- Sheree Jenkins-Tucker, GA Mental Health Consumer Network
- Ike Powell, Empowerment Partners, Inc.
- Mary Shuman, Appalachian Consulting Group

In addition, these individuals presented information on peer specialist training initiatives sponsored by their organizations during Module 19 (Day 4):

- Lori Ashcraft (META Services)
- Bill Burns-Lynch (MHA of Southeastern PA)
- Vicki Cousins (State of SC)
- Mike Halligan (TX Mental Health Consumers Association)
- Bill Lennox (State of HI)
- Kathy Muscari (CONTAC/WV Mental Health Consumers Association)
- Frances Priester (DC Department of Mental Health)

Evaluation of the Training

In order to determine whether measurable changes in knowledge occurred as a result of the training, a pre-test/post-test evaluation methodology was employed. The pre-test/post-test instrument was designed by the University of Illinois at Chicago (UIC) Center for Mental Health Services Research and Policy (CMHSRP), using copies of the training material and overviews of the modules, as well as feedback from the trainers. For some modules, trainers had already devised questions, which were then reviewed and refined by CMHSRP staff. Once a set of questions had been developed, it was reviewed by CMHSRP researchers, PPRC staff, and program trainers for fidelity to the content of the training, and level of difficulty. In addition to the content area questions, a section was included to elicit demographic characteristics of the participants, and a satisfaction survey component was included in the evaluation protocol. The

satisfaction survey consisted of 5 items assessing participants' reactions to the overall training experience, and separate items rating 3 dimensions of each individual training module.

Given the diversity in experience and beginning knowledge levels of the training participants, the questions were deliberately designed to reflect a high level of difficulty. This was done to enhance the utility of items in measuring knowledge change, since knowledge transfer is the primary goal of the training program. Readers of this report therefore may be surprised at the relatively low "scores" on tests, but should keep in mind that these tests were not designed to reflect the respondents' full state of knowledge at post-test so much as the *degree* of knowledge *acquired in the course of the training*. Since it would be very unlikely for anyone, expert or otherwise, to answer all of the items correctly, the equivalent of an "A" or good score on these tests would be below 100%. Of more importance and interest is whether participants demonstrated improvement in scores between the pretest and the posttest and the degree to what improvement occurred.

Identical tests were administered and collected by PPRC staff before and after training on each day. Copies of the completed instruments that were stripped of identifying information and assigned identification numbers were used for data entry and analysis by CMHSRP. The pre/post tests consisted of 72 items covering 27 peer-to-peer training modules. The only module not covered by the pre-test/post-test was module 19, entitled "Overview of Peer Specialist Models." This module was not included in the evaluation instrument because no information was made available to CMHSRP staff for question development. For data quality control and assurance purposes, a 5% random sample was selected for double data entry. Errors were found in only 1% of all keystrokes. These data were cleaned and further quality checks were conducted, including examination of data for outliers and other unexpected and/or unexplainable values. The data were then recoded so that correct answers were coded as "1" and incorrect answers as "0." Partial credit was given for each correct answer in multiple-part, open-ended questions. Each participant's scores were summed to create a total score, and then divided by 72 to create a percentage correct score out of 100%. The data come from 40 respondent trainees, with minimal missing data. The following presents the number of respondents who did not complete the pre-test/post-test instrument by module number.

2 respondents missed pre/posts for Day 1 (modules 1-3)
2 respondents missed pre/posts for Day 2 (modules 4-9)
1 respondent missed pre/posts for Day 3 (modules 10-15)
3 respondents missed pre/posts for Day 4 (modules 16-21)
2 respondents missed pre/posts for Day 5 (modules 22-27)
2 respondents missed pre/posts for Day 6 (module 28)

Evaluation Results

Demographic Characteristics

Details of the demographic characteristics of the training participants are shown in Table 1. A little over half of the program trainees were female (56%), and almost a fifth (19%) represented racial or ethnic minority groups, mostly African American (8%) or Hispanic/Latino

(6%). Trainees' ages ranged from 30-72 years, with an average close to 48 years of age. Almost a third (31%) had a graduate or professional degree, and over a third (36%) had a 4-year college degree. A quarter had either a 2-year college degree (6%) or some college (17%). The remaining trainees had a technical certification, some post-secondary training, or a high school diploma or equivalent (11%). In terms of marital status, almost half reported being divorced or separated (47%), almost a third were married or living with a partner (28%), 19% were single and never married, and 6% were widowed. Almost three-quarters (73%) were employed: 57% were working full-time, 3% part-time, and 13% on a contractual or hourly basis. Close to two-fifths (38%) were currently or formerly a provider of mental health or other social services. All trainees were currently receiving mental health services and over two-thirds (69%) had experienced a psychiatric hospitalization. These characteristics are shown in Table 1.

Table 1. Demographic Characteristics of Training Program Participants

Trainee Characteristics		Percent or Average (N=40)
Gender		
	Male	44%
	Female	56%
Race/Ethnicity		
	European-American (white)	81%
	African American	8%
	Hispanic/Latino American	6%
	Native American/Alaskan.	3%
	Other/mixed	3%
Age		
	Range	30-72 years
	Average	47.6 years
	Median	38 years
Education		
	graduate/professional degree	31%
	4-year college degree	36%
	2-year college degree	6%
	some college	17%
	technical training/certification or high school diploma/GED	11%
Household Income		
	>= $75K/year	19%
	$60K-$74,999	3%
	$45K-$59,999	17%
	$30K-$44,999	17%
	$15K-$29,999	14%
	<$15K	31%

Trainee Characteristics		Percent or Average (N=40)
Marital Status:		
	never married/single	19%
	cohabiting/married	28%
	divorced/separated	47%
	widowed	6%
Employment Status		
	currently employed full-time	57%
	currently employed part-time	3%
	hourly/consulting/contractual	13%
Current or past mental health or social services provider		38%
Mental Health Services Use		
	currently using MH services (4 missing responses)	100%
	ever hospitalized for MH reasons	69%

Changes in Knowledge Levels

Individual participants' pre- and post-training scores were compared using paired *t*-tests. Table 2 shows results for all modules and days of training combined. The scores are shown as both the sum of correct answers, and as a percentage of the sum of correct answers out of the total number of questions (n=72). The results indicate a significant increase in knowledge following the training. On average, the trainees answered nine more items correctly on the post-test than the pre-test, an increase of close to 12%. The significant p-value of the paired *t*-tests indicates that an increase of this size is extremely unlikely ($p<.001$) to be due to random error or chance. Here we see that the overall scores are not high, which is a function of the extreme difficulty of questions administered.

Table 2. Total and percent pre/post test results for entire sample (n=40)

Measure	Description	Pre- mean (s.d.)	Post- mean (s.d.)	Paired *t*-test p-value (2-tailed)
Raw Total Score	Sum of correct answers	35 (7.8)	44 (10.1)	<.001
Percent Total Score	Sum of correct answers/72	48% (11%)	60% (14%)	<.001

Separate paired t-tests were computed for each module, and the results are shown in Table 3. There were statistically significant increases in the percentage of correct answers in more than half of the modules tested (15 out of 27, or 55%). In most of the remaining modules, the scores increased, although not at a statistically significant level. In two modules, the scores decreased slightly but again, not significantly.

Table 3. Percent pre/post tests for each module separately (bolded rows indicate statistically significant change)

	Entire sample (n=40)		
Module	Pre-average percent score	Post-average percent score	Paired t-test p-value (2-tailed)
All modules	**48%**	**60%**	**<.001**
1	75%	77%	Ns
2	**50**	**78**	**<.001**
3	**69**	**88**	**<.001**
4	58	56	Ns
5	87	92	Ns
6	92	93	Ns
7	58	63	Ns
8	82	86	Ns
9	**43**	**58**	**<.03**
10	**52**	**74**	**<.001**
11	**35**	**55**	**<.01**
12	**32**	**52**	**<.001**
13	**25**	**57**	**<.001**
14	**24**	**59**	**<.001**
15	**17**	**50**	**<.001**
16	**32**	**47**	**<.03**
17	**54**	**85**	**<.001**
18	53	48	Ns
20	**47**	**58**	**<.03**
21	69	76	Ns
22	39	43	Ns
23	**52**	**69**	**<.01**
24	63	66	Ns
25	79	87	Ns
26	**3**	**72**	**<.001**
27	**31**	**41**	**<.04**
28	36	41	Ns

Finally, statistical associations among trainee characteristics, trainee satisfaction, and their test scores were examined using Pearson correlation. Table 4 shows that some statistically significant

correlations were found. In particular, trainees who were either currently or had in the past been employed as mental health or social service providers had generally higher scores on the pre-tests than other trainees ($r=.35$, $p<.05$). In addition, trainee level of education was correlated positively with pre-test scores, such that trainees with higher levels of formal education scored significantly higher than those with lower education on the pre-tests ($r=.34$, $p<.05$). Both of these associations were not surprising given that those who had experience providing services in the social services field and those with more formal education might be expected to score higher than their counterparts on an initial test of knowledge. Female trainees tended to score lower than male trainees on the pre-tests ($r=-.40$, $p<.05$). In addition, higher satisfaction with the overall quality of the training, and the feeling that the training met participants' needs was correlated with lower pre-test scores ($r=-.35$ and $r=-.38$ respectively, both $p<.05$). Again, this result is not surprising given that those with lower initial levels of knowledge had presumably more to gain from the training and were therefore more likely to be satisfied by it. Those with past or current employment as a mental health or social services provider scored significantly higher than those who were not on post-test scores ($r=.35$, $p<.05$). However, gender and education were not correlated with post-test scores even though they had been associated with pre-test scores. Finally, higher satisfaction with the overall quality of the training, and feeling that the training met participants' needs were correlated with lower post-test scores ($r=-.35$, $p<.05$, and $r=-.44$ $p<.01$, respectively). It is interesting to note that two correlates of pre-test scores (gender and education) were no longer associated with participants' post-test scores, suggesting that the training may have been especially effective in enhancing knowledge levels for these two groups by eliminating their pre-test disadvantage.

Table 4. Significant correlations between demographic characteristics, satisfaction measures, and pre/post-test scores*

Trainee Characteristic/Satisfaction Level	Correlation with Pre-test score	Correlation with Post-test score
Employed as a mental health or social services provider	.35*	.35*
Education	.34*	--
Female	-.40*	--
Satisfaction with overall quality of training	-.35*	-.35*
Satisfaction with training meeting overall needs	-.38*	-.44**

* $p<.05$
** $p<.01$

Satisfaction with Training

Trainees responded to five questions about the overall quality of the training, and their responses are summarized in Table 5. All respondents rated the training as excellent (71%) or good (29%) in meeting their interests and needs. Regarding the quality of the training materials: 69% rated training quality as excellent, 28% as good, and only 3% as poor. Overall, the presenters were rated as either excellent (83%) or good (17%). In overall training program quality, respondents

rated the program as either excellent (83%) or good (17%). Almost all attendees said they would recommend the training to others (92%), while 8% said that "perhaps" they would recommend the training to others.

Table 5. Trainee satisfaction with five aspects of the overall training.

Overall Training Satisfaction Items	Poor	Good	Excellent
Thinking about the entire Training Program, how well did the overall content meet your interests/needs?	0%	29%	71%
How would you rate the overall quality of the training materials?	3%	28%	69%
How would you rate the overall quality of the presenters?	0%	17%	83%
How would you rate the overall quality of the Training Program?	0%	31%	69%
	No	Perhaps	Yes
Would you recommend this Training Program to others?	0%	8%	92%

In addition to the questions on overall quality, participants were asked to rate each module individually, using three criteria of content, materials, and presenter(s) quality. Specifically, trainees were asked: How well did the content of *this session* meet your interests/needs? How would you rate the quality of the training materials for *this session*? and How would you rate the quality of the presenter(s) for *this session*? Each item was rated on a three-point scale of poor, good, or excellent. The average ratings of each item for each module are shown in Table 6, along with averages of the three items for each module, and averages across all modules of each item. In general, the results were positive, with all modules and items scoring between 2 (good) and 3 (excellent). Across all modules, participants were most satisfied with the quality of the presenters (2.7).

Table 6. Average Respondent Ratings* of Each Module

Module/Session	Content	Materials	Presenter (s)	Average
(1) Overview	2.6	2.5	2.8	2.6
(2) Evidence-Based Practices & President's Report on Mental Health	2.4	2.5	2.7	2.5
(3) Role of Peer Support in the Recovery Process	2.7	2.7	2.8	2.7
(4) Values and Beliefs Supporting the Recovery Process	2.7	2.6	2.8	2.7
(5) Is Recovery Really Possible & How Negative Messages Are Sent	2.8	2.7	2.8	2.8
(6) The Power of Negative Messages & Creating Recovery Environments	2.8	2.6	2.8	2.7
(7) Psychosocial Rehabilitation as the Road to Recovery	2.6	2.5	2.6	2.5
(8) Mental Illness Diagnoses	2.3	2.4	2.6	2.4
(9) Reclaiming Your Power During Medication Appointments	2.6	2.5	2.7	2.6

Module/Session	Content	Materials	Presenter (s)	Average
(10) The Impact of Diagnosis on One's Self-Image	2.6	2.6	2.7	2.6
(11) Effective Listening & the Art of Asking Questions	2.8	2.7	2.8	2.7
(12) Facilitating Recovery Dialogues	2.5	2.5	2.6	2.5
(13) Dissatisfaction as an Avenue for Change	2.6	2.5	2.7	2.6
(14) Ten Steps to Creating the Life You Want	2.6	2.6	2.7	2.6
(15) Facing Your Fears	2.6	2.6	2.8	2.7
(16) Combating Negative Self-Talk	2.7	2.7	2.8	2.7
(17) Problem Solving with Individuals	2.6	2.5	2.6	2.6
(18) Cultural Competency	2.4	2.2	2.7	2.4
(19) Overview of Peer Specialist Models	2.3	2.2	2.4	2.3
(20) Power, Conflict and Integrity in the Workplace	2.4	2.4	2.5	2.4
(21) Spirituality and Recovery	2.4	2.2	2.6	2.4
(22) Supported Employment as an Evidence-Based Practice	2.6	2.6	2.7	2.6
(23) Supported Employment & Federal Work Incentives, Part 1	2.3	2.4	2.7	2.5
(24) Supported Employment & Federal Work Incentives, Part 2	2.3	2.4	2.6	2.4
(25) The Role of Employment in the Recovery Process	2.7	2.7	2.8	2.7
(26) Supported Employment & Peer Support Groups	2.6	2.6	2.8	2.6
(27) Creating Your Wellness Recovery Action Plan (WRAP)	2.7	2.8	2.8	2.8
(28) Employment WRAP	2.6	2.6	2.7	2.6
Average across modules	2.6	2.5	2.7	2.6

*Rating scale is 1=Poor, 2=Good, 3=Excellent

It is interesting to note that, in general, the modules rated higher in satisfaction among trainees were the same modules associated with statistically significant increases in knowledge level at post-test. Other modules that were rated highly in terms of satisfaction were those that were highly interactive and involved group activities and role-playing. The top five rated modules are described below.

The module rated highest in satisfaction among trainees was Module 5: *Is Recovery Really Possible & How Negative Messages Are Sent?* This module involved participant group activities. Trainees were split into groups that were asked to list 5-7 supporting reasons for one of the following statements:

1. "Most people diagnosed with a severe and persistent mental illness cannot be expected to live a meaningful and productive life in the community."
2. "Most people diagnosed with a severe and persistent mental illness can be expected to live a meaningful and productive life in the community."

Responses were then shared and discussed with the group as a whole. Participants were encouraged to choose oppositional "Devil's Advocate" positions in order to stimulate discussion. The second part of the module focused on traditional mental health service delivery environments and how they reflect negative beliefs and low expectations of people within these systems because of the ways in which the environments are designed and structured. The pre-post test of this module indicated an increase in knowledge, but not at a statistically significant level.

The next highest rated module was Module 27: *Creating Your Wellness Recovery Action Plan (WRAP).* After a brief overview of the philosophy and purpose of the Wellness Recovery Action

Plan (WRAP) developed by Mary Ellen Copeland, trainees split into several small groups led by WRAP trainers and developed their own WRAP plans. Analysis of the pre-post tests indicated a significant increase in knowledge resulting from this module, as well as the high level of participant satisfaction.

The third highest rated module was Module 11: *Effective Listening & the Art of Asking Questions*. This module focused on using questions and sincere listening as tools for communication and discovering a consumer's insights, strengths, and desires. Trainees split into pairs, with Person #1 talking for three minutes about anything s/he wanted to talk about and Person #2 listening. Roles were then reversed. Group discussion followed on what happened from the perspective of both the person talking and the person listening. Trainees showed significant increases in knowledge following this module.

The fourth highest rated module was Module 3: *The Role of Peer Support in the Recovery Process*. Trainees were asked to create and post their own definitions of "peer support," followed by group discussion of what makes peer support unique and essential for recovery. Again, trainees showed significant increases in knowledge following this module.

The fifth highest rated module was Module 25: *The Role of Employment in the Recovery Process*. Training in this module included a power point presentation and accompanying discussion on the importance of employment to consumers as a tool for recovery, the philosophy and basic components of Supported Employment, and factors that increase success in job placement. Although knowledge increased following this module, it was not a statistically significant change.

Qualitative Evaluation

Trainees were invited to write additional comments at the end of the satisfaction survey. Participants seemed to have especially positive reactions to the group exercises, and to the presenters:

> *This was a phenomenal training! I think the sequencing of the modules was excellent. I thought the experiential exercises were extremely helpful and a great way to learn about ourselves.*
>
> *The training flowed well. The teachers were great and considerate. Good interaction. I loved the size of the group. Very empowering.*

There were concerns with the pre/post test content, the length of the day, and amount and quality of materials. For example:

> *I think the review questions at the end of almost all the sessions need work. I think many areas need to be expanded upon. Felt rushed in several areas.*
>
> *I'd have preferred a larger training – or getting some materials in advance. For every hour of training (for most sessions), I could have used 1 1/2 hours.*

Content hopefully to be reviewed and edited for continuity, diverse perspectives, and user-friendly aids.

Other comments indicated diversity of the trainees and the comprehensiveness of the training, which was covering new and different ground for some, as indicated in this comment:

Was it necessary to spend so much time on Soc. Sec. Details since we will be referring people to specialists in this area? We should talk about the language of Recovery! I don't like the word consumer or mental illness. I think more fidelity to WRAP as it is written is important.

General comments on the training were positive, including:

I looked forward to every day, and enjoyed studying for the first time in years.

More and continuous training of this kind. Thank you so much!

A really good start in the right direction.

Conclusion

Following completion of the Peer Specialist Certification Training Program conducted by the Peer to Peer Resource Center, statistically significant increases were observed in participants' knowledge about the mental health system, supportive counseling skills, and peer to peer service provision. Moreover, scores on the challenging pre- and post-tests indicated significant changes for most of the modules. Although participants who were male or had higher levels of education had higher scores on pre-tests, this advantage was not evident at post-test, indicating that the training was effective regardless of these two demographic characteristics or initial knowledge levels. In addition, participants in the training program expressed uniformly high levels of satisfaction with the training, and overwhelmingly agreed that they would recommend it to others. There seems to be room for some improvement in the materials used to teach certain modules and, for some participants, the training was too fast-paced and intense. On the other hand, participants were particularly positive about the trainers and the group experiential teaching methods, while satisfaction with content and training materials was also high.

Appendix

Schedule of training modules

National Peer Support Certification Training Program						
Time	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
8:30-9:30		(4) Values and Beliefs Supporting the Recovery Process	(10) The Impact of Diagnosis on One's Self-Image	(16) Combating Negative Self-Talk	(22) Supported Employment as an Evidence-Based Practice	(28) Employment WRAP
9:30-9:45		BREAK	BREAK	BREAK	BREAK	BREAK
9:45-10:45		(5) Is Recovery Really Possible & How Negative Messages Are Sent	(11) Effective Listening & the Art of Asking Questions	(17) Problem Solving with Individuals	(23) Supported Employment & Federal Work Incentives, Part 1	(29) Review of Training, Revisiting of Values and the Testing Process
10:45-11:00		BREAK	BREAK	BREAK	BREAK	BREAK
11:00-12:00		(6) The Power of Negative Messages & Creating Recovery Environments	(12) Facilitating Recovery Dialogues	(18) Cultural Competency	(24) Supported Employment & Federal Work Incentives, Part 2	(30) Evaluation and Next Steps
12:00-1:00	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
1:00-2:00	(1) Welcome, Introductions and Overview of the Training	(7) Psychosocial Rehabilitation as the Road to Recovery	(13) Dissatisfaction as an Avenue for Change	(19) Overview of Peer Specialist Models	(25) The Role of Employment in the Recovery Process	
2:00-2:15	BREAK	BREAK	BREAK	BREAK	BREAK	
2:15-3:15	(2) Evidence-Based Practices & President's Report on Mental Health	(8) Mental Illness Diagnoses	(14) Ten Steps to Creating the Life You Want	(20) Power, Conflict and Integrity in the Workplace	(26) Supported Employment & Peer Support Groups	
3:15-3:30	BREAK	BREAK	BREAK	BREAK	BREAK	
3:30-4:30	(3) Role of Peer Support in the Recovery Process	(9) Reclaiming Your Power During Medication Appointments	(15) Facing Your Fears	(21) Spirituality and Recovery	(27) Creating Your Wellness Recovery Action Plan (WRAP)	
Evening	Free Time	Free Time	7:00-8:00 DTR Groups	Free Time	Free Time	