Peer Services Toolkit

A Guide to Advancing and Implementing Peer-run Behavioral Health Services

12/31/2014; Revised 04/30/2015

Recommended Citation: Hendry, P., Hill, T., Rosenthal, H. Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services. ACMHA: The College for Behavioral Health Leadership and Optum, 2014

PEER SERVICES TOOLKIT

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ACKNOWLEDGEMENTS

In 2012, members and supporters of ACMHA: The College for Behavioral Health Leadership who shared a lived experience of recovery from mental health and substance use related conditions came together to form the ACMHA Peer Leaders Interest Group (PLIG).

Building on ACMHA's mission, the PLIG has sought to provide the peer recovery community with a "premier forum for the development of leaders and the exchange of innovations that impact the health and wellness of communities and people with mental health and substance use conditions." (See page 58 for a list of individuals who have participated on PLIG calls or at face-to-face meetings and events at ACMHA's annual Summit.)

In late 2013, ACMHA and the PLIG were funded by Optum to explore an issue of primary concern to both: the unprecedented opportunities and challenges that peer-run services currently face during the implementation of national healthcare reform.

As a result, representatives from over 20 nationally recognized peer mental health and addiction service agencies were able to participate in a March 25, 2014 ACMHA Peer Leaders Seminar that preceded the 2014 Annual ACMHA Summit in Santa Fe, New Mexico.

During the day-long program, they shared common concerns that have helped to inform this ACMHA Peer Services Tool Kit, which is aimed at

- supporting efforts to advocate and expand the capacity, capability and scope of peer services while
- providing valuable background information for federal, state and local governments and for new payers.

We want to express our heartfelt thanks to **Patrick Hendry** for his primary authorship of this Tool Kit, Sue Bergeson, Optum's Vice President of Consumer Affairs and Kris Ericson, AMCHA Executive Director for their extraordinary support of this effort and PLIG members, Chacku Mathai, Ben Bass, and Steve Hornberger for their input.

Tom Hill, Harvey Rosenthal Co-Chairs, ACMHA Peer Leaders Interest Group
December 2014

Note: While the terms 'peer support' and 'peer-run services' are used interchangeably, peer support has traditionally been used to describe the "process of giving and receiving encouragement and assistance to achieve long-term recovery" regardless of whether this is professionalized via the delivery of a peer-run service.

SOME KEY DEFINITIONS

Peer Support and Mental Health and Addiction Recovery

Any discussion of peer supports and services in mental health and addictions treatment must first clarify the use of the term "peer". The Merriam-Webster Dictionary defines it as "*a person who belongs to the same age group or social group as someone else".* In behavioral health it is generally used to refer to someone who shares the experience of living with a psychiatric disorder and/or addiction with another. In that narrow context two people living with those conditions are peers, but in reality most people are far more specific about whom they would rely on for peer support.

For example, when the Veterans Administration developed peer specialist positions to work with individuals with psychiatric disorders, and/or with substance use disorders, veterans were very clear that their peers must also be veterans. Even more specifically, combat veterans are generally most comfortable working with peer specialists who have also experienced combat.

These same feelings hold true for many individuals, although what it takes for them to consider someone a peer may vary and may include, race, gender, sexual orientation, ethnicity, age, and other human conditions. It is up to the individual receiving support to decide whom they can relate to as peers. It is the responsibility of the agency providing peer support to ensure that the peers they hire match the demographics of the people being served as much as possible. Accordingly, awareness and understanding of cultural diversity and relativity is essential.

In *Equipping Behavioral Health Systems & Authorities to Promote Peer Specialist/Peer Recovery Coaching Services*, SAMHSA says:

- A peer is a peer when he/she self-identifies as a peer and is willing to share his/her lived experiences with others.
- Peer support services should strive to recruit a diverse cadre of peers so that people with a range of backgrounds and experiences might find the possibility of connection.
- Peers/coaches may be volunteers or paid for their work.

  SAMHSA (2012)

What Is Peer Support?

"Peer support is the process of giving and receiving encouragement and assistance to achieve long-term recovery. Peers offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people." Mead, S. (2003); Solomon, P. (2004)

It can involve the provision of informational, emotional, social, and/or material aid that help advance individual's recovery capital (supportive relationships) and community capital (referral sources). "A broad definition of peer support is any organized support provided by and for people with similar conditions, problems, or experiences." O'Hagan, M. (2011). Peer support occurs when people share common concerns or problems, and provides emotional support and coping strategies to manage problems and promote personal growth (Davidson, et. al, 1999). "Recovery Capital is the breadth and depth of *internal* and *external* resources that can be drawn upon to initiate and sustain recovery." Granfield, R., Cloud, W. (1999); White, W. (2006)

"A peer provider (e.g. certified peer specialist, peer support specialist, recovery coach) is a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency." SAMHSA-HRSA Center for Integrated Solutions, (2014)

How do Peer Providers Apply the Principles of Peer Support?

Peer providers can play many roles in support for people living with psychiatric disorders and in addiction recovery. They are capable of providing facilitation for education and support groups, working as peer bridgers for individuals making the transition from hospitals or jails into the community, and working one-on-one as role models, mentors, coaches, and advocates. They also support people in developing psychiatric advance directives (http://www.nrc-pad.org/) and creating Wellness Recovery Action Plans (WRAP) plans (http://www.copelandcenter.com/wellness-recovery-action-plan-wrap).

Before, during and beyond crisis points they provide compassionate listening, and a positive vision of the future. Additionally peer providers can work with individuals in goal setting, and developing achievable action plans. They can play an important role in supporting people in self-managing and working towards whole health goals, and they are uniquely qualified to assist peers in connecting with their communities, building supportive relationships, accessing formal and informal resources, and working with cultural humility to support people across a wide range of cultural differences.

Peer providers can work with peers who are homeless and seeking safe, permanent housing or placements in recovery residences that offer community through group living in substance-free environments.

What is Recovery?

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA (2014). It can also involve three critical elements: 1) sobriety (abstinence from alcohol, tobacco, and/or un-prescribed drugs), 2) improvement in global health (physical, emotional, relational, and

ontological – life meaning and purpose), and 3) citizenship (positive participation in and contribution to community life).

Recovery means different things to different groups. For example a person with AA as a context would consider abstinence as a criterion for successful recovery, among other spiritual markers. A person in Women for Sobriety achieves abstinence and self-actualization while Rational Recovery achieves abstinence through a personal commitment to oneself.

Through the *Recovery Support Strategic Initiative*, SAMHSA has delineated four major dimensions that support a life in recovery:

- Health: overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- Home: a stable and safe place to live;
- Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- Community: relationships and social networks that provide support, friendship, love, and hope.

To view SAMHSA's *Guiding Principles of Recovery* and the findings of the *Recovery Support Strategic Initiative* go to: *http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.VDVeCYmBHrc.*

"Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship." Betty Ford Clinic (2007)

"Whether your mental health or substance abuse problem came first, recovery depends on treating *both* conditions.

- There is hope. Recovering from co-occurring disorders takes time, commitment, and courage. It may take months or even years but people with substance abuse and mental health problems *can* and *do* get better.
- Combined treatment is best. Your best chance of recovery is through integrated treatment for both the substance problems and the mental health problem. This means getting combined mental health and addiction treatment from the same treatment provider or team.

Relapses can be part of the recovery process. Don't get too discouraged if you relapse. Slips and setbacks happen, but, with hard work, most people can recover from their relapses and move on with recovery. Helpguide.org (2014

PEER SUPPORT AND RECOVERY

Anonymous quotes from people in recovery using peer supports:

"Knowing you are not alone. Seeing that you are able to live with a mental health diagnosis and still go to school, get a degree, have a job, have a relationship and family. Feeling you are more "normal" or "okay."

"One thing that unites us is feeling that we haven't had a voice in our own lives."

"A huge part of getting better does not come from doctors but comes from peers.

"If it were not for peer support I wouldn't be alive."

"Peer support got me through when I got nothing from the formal system."

"Peer support saves lives, PERIOD!"

SAMHSA, (2012), O'Hagan, M. (2011)

Recovery is a non-linear process; it is not a defined set of tasks that are the same for everyone to achieve long term recovery. Rather, it is highly individual and is often a series of times of progress and times of relapse. As stated above, there are many common elements to recovery and therefore each of us can gain from the examples of those further along in the process, and quality services and supports are highly beneficial to all.

PEER SERVICES OUTCOME DATA

Peer-run Services Excel in Outreach, Engagement and Effecting Reductions in Inpatient and Emergency Services

Significant research shows that peer support is effective in:

- engaging and retaining people in mental health and addiction services,
- supporting individuals in playing active roles in their treatment through empowerment
- lowering re-hospitalization rates,
- reducing utilization of crisis and emergency room services.

Moreover, peer services play crucial roles in helping individuals to advance their wellness and recoveries in the community, demonstrating a significant role in:

- increasing overall satisfaction with services
- providing knowledge about psychiatric disorder and addictions, and their management
- assisting in connecting to communities
- reducing symptoms and or substance use
- improvements in practical outcomes e.g. employment, housing, and finances
- increasing ability to cope with stress
- increasing quality of life
- increasing ability to communicate with mainstream providers
- positive outcomes in chronic illness
- significant increases in outpatient services
- reducing relapse and initiating recovery engagement when relapse occurs

Lucksted, A. et al, (2009); Campbell, J. et al (2003); Chamberlin, J. et al, (1996); Cook, J. et al, (2010); Humpheys, K. et al, (2004); Lawn, S., et al, (2008), McLean, J., et al, (2009) Kyrouz, E. M. et al, (2002); Optum Behavioral Health (2014)

Many of these enhanced outcomes result in significant savings to states, behavioral health services and the social safety net. *Mental Health Peer Support: Effectiveness and Cost-Effectiveness* provides important data on peer support in the field of mental health and underscores the potential of peer support to provide cost savings by supplementing the mental health workforce and reducing the need for costly crisis care and hospitalizations. Velicer, C. (2013)

Some Results from Optum funded Peer Service

Optum is unique in its data collection demonstrating the success of several peer service initiatives it has funded:

Peer Bridger (2013 evaluation)

Decrease in number of people who use inpatient services	Percentage
New York*	47.9%
Wisconsin	38.6%
Decrease in number of inpatient days	
New York*	62.5%
Wisconsin	29.7%
Increase in number of outpatient visits	
New York*	28.0%
Wisconsin	22.9%
Decrease in total Behavioral Health Costs	
New York*	47.1%
Wisconsin	24.3%

* The New York-based outcomes were achieved via the application of the peer bridger model that was created and delivered by the New York Association of Psychiatric Rehabilitation Services (NYAPRS)

Optum Peer-Based Crisis Response (Pierce County, Washington 2003 evaluation)

- Peer-run Warm Line: responds to individuals in crisis to avoid relapses and readmissions
- Crisis Line: Professional, training by peers on recovery and resiliency, and "lived experience"
- Crisis Response Team: Includes a trained peer
- Police CIT (Crisis Intervention Team) trained by peers
- Living Room (Recovery Innovations model): Intake by peers, focus on strengths and recovery goals
    - Ability to sleep, offered healthy comfort food
    - 50% clinical and 50% peer support staff on the team
    - Team helps consumers find solutions in times of crisis, avoiding automatic hospitalization or involuntary detention
    - Stay up to 3 days, moved into hospital if clinicians and consumer agree this is needed. Involuntary commitment avoided most of the time
    - Consumers reported a 91% satisfaction rate for this program

Optum Peer Based Crisis Response: One Example

	Prior Year FY 2009	Optum FY 2010	Optum FY 2011	Optum FY 2012
Individuals Served 32.0% increase in individuals served annually	12,121	15,262	15,410	16,005
Total covered county population		1,399,846	1,492,221	1,535,745
Reduction in Hospital Admissions	123	99	79.25	71.6

32.3% reduction in hospitalizations	monthly	monthly	monthly	monthly
Involuntary Treatment Act Reduction 32.1% reduction in ITA $5.0 million est. cumulative 3 year savings	83.6 monthly	56.8 monthly	55.8 monthly	57.58 monthly
Re-admission Rate (30 days) 26.5% reduction in re-admission rate $0.5 million est. cumulative 3 year savings	12.6%	8.6%	10.75%	8.45%
Inpatient Bed Days per 1000 35.0% below state average $12.0 million est. cumulative 3 year savings	19.60	12.13	12.37	13.73

Optum Peer Wellness Coaching (NYS Chronic Illness Demonstration Program 2008-11): Another Example

The NYS Department of Health reported that a Queens-based Optum/NYAPRS peer wellness coach helped engage and support a 36 year old individual with a history of serious mental health, addiction and medical conditions to reduce detox unit readmissions from 7 to 1 over the course of one year, resulting in an over 50% drop (from $52,000 to $20,000) in total Medicaid behavioral health expenditures.

Other Peer Service Outcomes

- 90% of **PEOPLe Inc's Rose House crisis respite program** (Orange County, NY) participants did not return to hospital in the following two years, 2010 program evaluation data
- **Mental Health Peer Connection's Life Coaches** helped 53% of individuals with employment goals to successfully return to work in the Buffalo, NY area, 2010 program evaluation data
- Western NY's **Housing Options Made Easy** helped 70% of residents to successfully stay out of hospital in the following year, 2011 program evaluation data

THE HISTORY OF PEER SUPPORT

The Peer Support movement began in mental health in England in 1845 out of an effort led by John Perceval, who worked tirelessly to reform conditions in that nation's asylums. O'Hagan, M. (2011)

"The history of addiction treatment and recovery in the United States contains a rich "wounded healer" tradition. For more than 275 years, individuals and families recovering from severe alcohol and other drug problems have provided peer-based recovery support (P-BRS) to sustain one another and to help those still suffering." White, W. (2009)

The new wave of peer support in mental health came from the emerging consumer/survivor/ex-patient movement beginning in the 1960's, around the same time as the civil rights movement, gay rights, the women's movement, and the Native American movements. The movements were driven by anger from inhumane treatment, oppression, and the fight for self-determination. Groups of advocates drew people from across the country and around the world, who had been released from asylums and psychiatric hospitals, and laid the groundwork for the peer support movement of today.

As people who had been released from institutions began to come together in the streets, churches, and campgrounds they began to support one another by sharing their personal stories and their strengths. Peer-run support groups and self-help began to appear around the country.

In the late 1970's peers like New York City's Howie the Harp began to form communal centers, later called drop-in centers. These were places where people came together to be in an environment that was safe and non-judgmental, or stigmatizing. They were centers for education and advocacy and the model has continued to evolve to connect people to their communities, and offer information on rights, advocacy, services and supports, recovery, and whole health.

In 1978, movement leader Judi Chamberlin published the seminal "On Our Own: Patient Controlled Alternatives to the Mental Health System."

Starting in the 1980's people began working within the system as advocates, peer counselors, and change agents. Many peer-run organizations began to grow around the country and peers began to contract with the state and local governments to provide services. The Federal government began to sponsor, through grants, peer-run centers to provide information and advocacy for self-help, and to support consumer/survivors/ex-patients in forming local and state organizations.

In 1998, SAMHSA initiated the Recovery Community Support Program (RCSP), a grant provided to addiction recovery community organizations (RCOs) to organize and mobilize constituents to influence public policy, educate communities, and address stigma. The RCSP evolved into a peer services program in 2001. Building on the history of peer support in mutual aid groups, such as Alcoholics Anonymous (AA), RCSP grantees pioneered a menu of peer services based on reciprocity and service ("giving back"). Over time many RCOs have developed peer services, creating a parallel thrust to the work being developed by mental health peers.

These 1998 grantees developed organizations built on the principles of their recovery communities, and many are still active today, providing peer leadership in the addiction peer recovery movement. They began from within a group of people who gathered together in the name of recovery before any organizing effort. They then organized and mobilized their grassroots peers, and this seems to have made the difference in their longevity and usefulness to the movement – that is the work of actually doing the organizing and staying close to the roots.

Over time peers began to offer support through increasingly sophisticated ways. We now have peer-run respite facilities, housing, employment agencies, crisis centers, recovery and wellness centers and a full range of behavioral health services that transcend cultural barriers.

ESSENTIAL ELEMENTS OF PEER SUPPORT

The overarching key to peer support is the relationship between the supporter and the person receiving support. If the individual feels that the supporter is a true peer, i.e. someone who has lived experience with psychiatric disorders and/or addictions, plus the other factors that are essential to the individual, then this basis for a supportive relationship is the foundation for assisting them in moving along their path to recovery.

A trusting safe relationship is based on acceptance, and empathy that is culturally sensitive, and promotes hope, respect and dignity. This allows for a degree of sharing, validating, and normalizing that is critical to the peer relationship. Building an honest, mutually responsible relationship with the intention to change patterns and get "unstuck" demonstrates full respect for each person's unique process of change. It supports them in persisting in their efforts towards recovery and in seeing the opportunities present in crisis, a time in which change is necessary, in treatment, life situations, and motivation. It helps them to focus on moving forward towards the positive changes they want versus negative-grounded focus on what they want or need to stop. In many ways, peer support readies people to engage and actively participate in more effective professional services, as well as self-management.

In a positive, supportive relationship boundaries and limits are negotiated between the peer supporter and the person receiving the support. The nature of the relationship is mutually accountable with responsibility shared by helper and the person receiving support. The peer supporter is an advocate, an intermediary and supporter of first and last resort.

Peer Specialist/Recovery Coach Role

What a Peer Supporter Is/Does	**Is Not/Does Not**
A person in recovery	A professional
Shares lived experience	Gives professional advice
A role model	An expert or authority figure
Sees the person as a whole person in the context of the person's roles, family, community	Sees the person as a case or diagnosis
Motivates through hope and inspiration	Motivates through fear of negative consequences
Supports many pathways to recovery	Prescribes one specific pathway to recovery
Functions as an advocate for the person in recovery, both within and outside of the program	Represent perspective of the program
Teaches the person how to accomplish daily tasks	Does tasks for the person
Teaches how to acquire needed resources,	Gives resources and money to the person

including money	
Helps the person find basic necessities	Provides basic necessities such as a place to live
Uses language based on common experiences	Uses clinical language
Helps the person find professional services from lawyers, doctors, psychologists, financial advisers	Provides professional services
Shares knowledge of local resources	Provides case management services
Encourages, supports, praises	Diagnoses, assesses, treats
Helps to set personal goals	Mandates tasks and behaviors
A role model for positive recovery behaviors	Tells person how to lead his/her life in recovery
Provides peer support services	Does whatever the program insists he/she do

SAMHSA's Bringing Recovery to Scale Technical Assistance Center Strategy (BRSS TACS) 2012

Peer Specialists support their peers both individually and in small groups. They:

- Help peers create individual service plans based on recovery goals and steps to achieve those goals
- Use recovery-oriented tools to help their peers address challenges
- Assist others to build their own self-directed wellness plans
- Support peers in their decision-making
- Set up and sustain peer self-help and educational groups
- Offer a sounding board and a shoulder to lean on
- Advocate with individuals for what they need
- Work within integrated health settings
- Support people in crisis
- Share their personal stories of recovery
  DBSA (2014), Jorgenson, J., Schmook, A. (2014)

Type of Social Support and Associated Peer Recovery Support Services

Type of Support	**Description**	**Peer Support Service Examples**
Emotional	Demonstrate empathy, caring, or concern to bolster person's self-esteem and confidence.	Peer mentoring Peer-led support groups
Informational	Share knowledge and information and/or provide	Parenting class Job readiness training

	life or vocational skills training.	Wellness seminar
Instrumental	Provide concrete assistance to help others accomplish tasks.	Child care Transportation Help accessing community health and social services
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.	Recovery centers Sports league participation Alcohol- and drug-free socialization opportunities

SAMHSA Center for Substance Abuse Treatment (2009)

PEER SUPPORT JOB DEFINITIONS AND DESIGNATIONS: AN OVERVIEW

There are a wide variety of peer support positions and designations, including:

Certified Peer Specialists: Peers who have sufficiently progressed with their recovery that they are ready to provide assistance to others. They have completed training and have met the certification standards of their states to provide peer support services

Certified Mental Health Peer Wellness Coaches or Whole Health and Resiliency Peer Specialists: Similar to CPS who work in a whole health environment. Peer wellness coaches support people to identify and meet their individualized wellness and healthy lifestyle related goals. They offer the structure and support to promote personal progress and accountability and help compile and share wellness and healthy lifestyle resources for peers. They are distinct from "peer navigators", who primarily advocate for and link individuals to services and supports.

Addiction Recovery Coaches or Mentors: Personal guides, mentors, and role models for individuals seeking to achieve or sustain long term recovery from addiction regardless of their pathways to recovery. Recovery coaches serve as connectors to recovery support services, like housing, employment, and other professional and nonprofessional services. They provide liaisons to formal to formal and informal community supports, resources and recovery supporting activities and can provide sober escort/transport, in-home meetings, live-in recovery support, telephone or internet-based recovery coaching, linkage to recovery support meetings, transportation to meetings, co-attendance at meetings, facilitation of virtual recovery groups, facilitation of daily readings, step work, meetings with families guidance on daily journaling, leisure activities, and daily nutrition. Recovery coaches are not sponsors or counselors.

Peer Bridgers: Peer Bridgers help individuals with long and/or recurrent involvements in a variety of institutional settings, like psychiatric hospitals, detox centers, adult and nursing home, and jails and prisons to make successful transitions to community living and reduces recidivism within those settings.

Peer Crisis Support Workers: Peer crisis support is provided as timely support to people in psychiatric crisis in a variety of settings, including phone based peer support lines, peer crisis respite centers (residential alternatives to emergency rooms) and as home peer companions. This peer support is aimed at working with a person to examine their experience with crisis and help them to decide what might be useful in the midst of a crisis.

Peer Advocates: Trained peer advocates help ensure a practice of reasonable accommodation, support consumer self-determination in shared decision making processes with providers, and assist individuals in accessing services and enforcing their human, civil, and legal rights in the mental health system.

Recovery Allies: providing recovery coaching as well as case management and resource brokering

Recovery and/or Wellness Center staff: Community or site-based support programs in which people support each other to develop networks of natural supports, pursue and protect their rights, and set and attain personal goals. Some centers promote ongoing recovery through creative endeavors such as art, music, poetry, and alternative approaches to healing such as yoga or Reiki.

Peer-Run Supported Housing (Mental Health): There is a strong link between having access to safe, secure and affordable housing and better health. Peer supported housing specialists assist individuals to successfully manage their recoveries and their lives in community-based apartments. New approaches to peer-run supported housing include explorations of home ownership, and a range of diverse consumer-directed, personal assistance and community support services focused on community membership and support.

Recovery Residences (Addiction Recovery): Recovery housing takes many forms, but all include group living with peers in an environment that is substance-free and promotes recovery culture norms.

Peer-Run Employment Support/Coaching Services: Peer coaches support individuals to find the resources to get out of poverty and participate in their communities through successful transitions to meaningful work.

Self-Directed Care Brokers/Coaches: Assist enrollees in self-directed care services to maximize the use of the flexible budgets controlled by the individual in these programs. They assist people in becoming aware of the broad range of goods and services that can aid them in their path to recovery.

Forensic Peer Specialist: Individuals living with psychiatric and/or addiction related conditions who have histories of incarceration. They receive special training to work in jails, prisons, and jail diversion programs to assist people in avoiding future incarceration and in connecting to their communities.

Certified Family Support Specialists: Family peer supporters who help build resiliency in care givers and youth.

Veteran Peer Specialists and Peer Support Technicians: Veterans who support other veterans with psychiatric disorders or addictions to successfully engage in their treatment.

VA Community Integration Specialist: Veterans who support other veterans with psychiatric disorders or addictions that are homeless.

Firestarters: Native American peer leaders responsible for building local recovery communities. (Jorgenson, J., Schmook, A., 2014)

Promotoras – Bilingual Peer Specialists: This peer-to-peer support method offers a culturally competent and cost-effective way to reduce mental health stress in Spanish speaking communities. Jorgenson, J., Schmook, A., 2014)

QUALIFICATIONS and CORE VALUES

Qualifications to be a Peer Support Specialist

Peer specialist training and certification requirements are determined on a state-by-state basis. A number of states administer their own peer specialist training and certification systems, while others contract with outside organizations to offer this training and certification. Some states permit individuals to complete state-approved training and certification programs offered by outside entities.

The Department of Veterans Affairs requires employed peer support technicians to complete either their state mental health department's approved training and certification process, or to be trained and certified by organizations whose training has been determined by the VA to equip peer specialists with necessary skills and competencies. DBSA (2014)

Most states require a minimum of a high school education or GED, and that the person be 18 years old or older. Some states require previous work experience in a peer support role prior to certification. For example Florida requires 1000 hours of paid or volunteer work to be certified through the Florida Certification Board. Many states require ongoing education or CEU's to maintain certification.

To qualify to bill Medicaid for peer support the Center for Medicare and Medicaid Services (CMS) requires that peer support providers must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders. Similar to other provider types, ongoing continuing educational requirements for peer support providers must be in place. CMS (2007)

Specific Qualities Required

- Person who has progressed in their own recovery, or has one year of addiction recovery who is actively involved in recovery activities
- Willingness to self-identify
- Willingness to share knowledge and experience of recovery
- Exhibits signs of a spiritual awakening
- Can act as a role model
- Listens and learns from people served
- Create environments that promote recovery
- Works in partnership with the individual
- Promotes trauma-informed care (asking 'what happened,' not 'what's wrong'

- Helps to navigate the system
- Helps individuals to examine personal goals and define in achievable ways
- Motivates change desired by the individual
- May act as liaison or proxy for the individual if desired

Core Values

SAMHSA has worked with a number of peer-run organizations, including, the International Association of Peer Specialists to create national standards for peer certification. The following core values have been ratified by peer supporters across the country:

- Peer support is voluntary
    - Peer supporters do not force or coerce others to participate in peer support services
    - Peer supporters respect the rights of those they serve
- Peer supporters are hopeful
    - Peer supporters tell strategic stories of their personal recovery that relate to the issues the people they serve are experiencing
    - Peer supporters model recovery
    - Peer supporters help reframe challenges as opportunities for growth
- Peer supports are open minded
    - Peer supporters embrace differences as potential learning opportunities
    - Peer supporters respect the individual's right to choose their personal path to recovery
    - Peer supporters connect with others where and as they are
    - Peer supporters do not evaluate or assess others
- Peer supporters are empathetic
    - Peer supporters practice effective listening skills and are non-judgmental
    - Peer supporters understand that while people may share similar life experiences their range of response may differ greatly
- Peer supports are respectful
    - Peer supporters embrace diversity as a means for growth for those they serve
    - Peer supporters encourage others to explore how differences can contribute to their lives and the lives of those around them
    - Peer supporters practice patience, kindness, warmth, and dignity with those they serve
    - Peer supporters see the people they serve as worthy of all basic human rights
    - Peer supporters embrace the full range of cultural experience, strengths and approaches to recovery
- Peer supporters facilitate change
    - Peer supporters find appropriate ways to call attention to injustice
    - Peer supporters strive to understand how injustices may affect people

    - Peer supporters encourage, coach and inspire people to challenge and overcome injustice
    - Peer supporters use language that is supportive, encouraging, inspiring, motivating, and respectful
    - Peer supporters help people explore areas in need of change
    - Peer supporters recognize injustice and act as advocates and facilitate change where appropriate
- Peer supporters are honest and direct
    - Peer supporters respect privacy and confidentiality
    - Peer supporters engage when desired by those they serve in candid, honest discussions about stigma, abuse, oppression, crisis, or safety
    - Peer supporters exercise compassion and caring in peer support relationships
    - Peer supporters do not make false promises, misrepresent themselves, others, or circumstances
    - Peer supporters strive to build relationships based on integrity, honesty, respect, and trust
- Peer support is mutual and reciprocal
    - Peer supporters learn from those they support and those supported learn from peer supporters
- Peer support is equally shared power
    - Peer supporters use language that reflects a mutual relationship with those they serve
    - Peer supporters behave in ways that reflect respect and mutuality
    - Peer supporters do not express or exercise power over those they serve
    - Peer supporters do not diagnose or offer medical services, but they do offer a complementary service
- Peer support is strengths-focused
    - Peer supporters encourage others to identify their strengths and use them to improve their lives
    - Peer supporters focus on the strengths of those they serve
    - Peer supporters use their own experience to demonstrate the use of one's strengths
    - Peer supporters operate from a strength based perspective and acknowledge the strengths, informed choices and decisions as foundations for recovery
    - Peer supporters don't fix or do for others what they can do for themselves
- Peer support is transparent
    - Peer supporters clearly explain what can and cannot be expected of the peer support relationship
    - Peer supporters use language that is clear, understandable, and value and judgment free
    - Peer supporters use language that is supportive and respectful
    - Peer supporters provide support in a professional, humanistic manner

    - Peer supporter roles are distinct from the roles of other behavioral health professionals
    - Peer supporters only make promises they can keep and use accurate statements
    - Peer supporters do not diagnose nor do they prescribe or recommend medications or monitor their use
- Peer support is person-driven
    - Peer supporters encourage people to make their own decisions
    - Peer supporters, where appropriate, offer options to people
    - Peer supporters encourage people to try new things
    - Peer supporters help people learn from their mistakes
    - Peer supporters encourage resilience
    - Peer supporters encourage personal growth in others
    - Peer supporters encourage and coach those they support to decide what they want in life and how to achieve it

National Practice Guidelines for Peer Supporters (2011)

During the course of research for this document it was recommended several times that national standards should include a stronger statement about peer supporters displaying a sense of cultural humility and a willingness to work without bias across the range of cultural diversity.

TRAINING AND EDUCATION

When peer support specialists work in publicly funded services, peer support specialists are required to meet certain government and state certification requirements. "Since the adaptation of the Recovery Management Model by state and federal agencies, peer support specialist courses have been offered by numerous state, nonprofit and for-profit entities such as Connecticut Community for Addiction Recovery, PRO-ACT (Pennsylvania Recovery Organization-Achieving Community Together), The McShin Foundation, Tennessee Certified Peer Recovery Specialist Training and Program, Appalachian Consulting Group and The State of New York's Office of Addiction Services. PARfessionals has developed the first internationally approved online training program for addictions recovery peer support specialists. In addition, there are numerous for-profit firms that offer peer support specialist training. Training includes courses on the ethics of a recovery coach, recovery coaching core competencies, clinical theories of stages of change, motivational interviewing, and co-occurring disorders." Wikipedia (2014)

Other leading trainings include:

- DBSA Peer Specialist Core Training
- Intentional Peer Support
- Howie the Harp Center Peer Training Program
- Institute for Recovery and Community Integration
- Recovery Within Reach
- Recovery Innovations Peer Employment Training
- Georgia Certified Peer Specialist Project
- Georgia Certified Addiction Recovery Empowerment Specialist (CARES)
- Recovery University, Connecticut
- VA Community Integration Specialist Training
- Texas Department of State Health Services Texas Peer Recovery Coach Institute
- Texas Department of State Health Services Via Hope Peer Support Specialist Training

Youth Move National is currently in the process of developing standards and training for youth peer support as are a number of other groups working with youth and young adults.

Some common elements included in many of the trainings are:

- The history of the peer movement
- Insight into Personal Recovery
- Five Stages of Recovery
- Role of Peer Support
- Creating Program Environments that Promote Recovery
- Stages of Change/The Dynamics of Change

- Effective Goal Setting that Promotes Successful Change
- Facilitating Support Groups that Promote Recovery
- Effective Listening
- Motivational Interviewing
- Facing One's Fears
- Combatting Negative Self Talk
- Problem Solving with Individuals
- Peer Specialist Ethics & Boundaries
- Power, Conflict and Integrity in the Workplace
- Creating the Life One Wants
- Wellness Recovery Action Planning WRAP
- Understanding the impact of trauma
- Working towards shared responsibility
- Looking at crisis as an opportunity
- Personal sharing and disclosure

It is important that peer support training emphasize cultural humility and the need to work with people across the range of cultural diversity. "Cultural competency involves embracing and acting on different cultural viewpoints—not setting them aside or simply accepting them. Acknowledging the heritage of people from diverse backgrounds is highly important." NAMI STAR Center (2010)

Certification and Accreditation

Currently there are a wide array of certification and certificate programs being used by states and regional and local certifying agencies. In some states it can be as simple as: anyone who takes an approved course is considered certified.

As the peer movement continues to grow across the country, peer networks are increasingly seeking opportunities to demonstrate the specialized knowledge and skills peers possess and the benefits of including peers on consumer's treatment teams. In order to be a successful peer, one must possess a combination of skills that, when taken together, indicate that the person possesses the level of knowledge and skill required in the profession, occupation, or role. As a relatively "new" workforce, it is incumbent upon peers to demonstrate their high standards of conduct, education and experience. One of the best means of doing so is to establish a professional credentialing program that is designed to reliably measure an individual's competency.

There are multiple options when determining how to measure competency – from a certificate program on one end of the continuum to complex, psychometrically sound professional certification programs. Regardless of the means selected to demonstrate competency, it is critical that the core competencies of a peer (knowledge, skills, job tasks, and performance domains of the profession) are identified according to a recognized process, such as a job task analysis or role delineation study. This is because –all other program requirements, policies, and standards must tie back to the core competencies of the profession being credentialed.

The only reliable measure of effective organizational capability to deliver addiction peer support services that has been developed in the addiction recovery community to accredit organizations and programs that provide peer services is the Council on Accreditation of Peer Recovery Support Services. It is the only accrediting body in the US for recovery community organizations and other programs offering addiction peer recovery support services. There has been considerable interest in the CAPRSS process of accreditation for similar peer organizations as well.

(For core competencies and role delineation studies see Appendix A)

Ongoing Education Opportunities for Peer Supporters

There are a variety of educational opportunities for peer support workers to continue their education. Increasingly, state certification programs are requiring continuing education as a requirement for re-certification. Some of the available trainings include:

- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Whole Health and Resiliency
- Ethics training
- Motivational Interviewing
- Co-occurring AOD and Mental Health Issues
- Trauma Sensitivity and Training in Trauma Informed Service Provision
- Enhanced certification programs
    - Forensics
    - Bridger
    - Homeless outreach
    - Substance use and addictions
    - Veterans
    - Family and youth

In order to continue to professionalize peer support and to develop new career opportunities for peers working in mental health and addiction recovery, it is important that peers employed in the behavioral health system be required to receive ongoing education and that such opportunities be available.

ENSURING THE INTEGRITY OF PEER SERVICES IN FREESTANDING AND EMBEDDED SETTINGS

Relationships Are the Key Element in Effective Peer Support and Peer-Run Services

The special importance and unique value of peer support and peer-run services lie in the essential central role and focus on relationships, on the development of positive, mutually accountable alliances that always "starts where the person is" and that focus on the stated needs of the individual over the needs of a system, funding stream or agency.

The literature is clear that the development of a positive and trusted helping relationship is far more an indicator of success than any particular treatment or therapy. The unique value and success of peer support lies in its offer of a relationship with someone who 'has been there' by virtue of their own past personal experience and who offers a genuinely empathetic and hopeful relationship that can always be trusted to key off of their experience and priorities.

In this way, peer supporters form relationships that typically address an individual's most pressing needs, where immediate access to housing, food, transportation and social support often takes precedence over typical system measures like engagement with treatment and the use of medications.

An individual's experience of their first contact with 'help' and the nature of the process that identifies 'treatment' goals can often dictate whether that individual will 'buy in' and commit to improved self-care and participation with services.

Freestanding vs. Embedded Peer Support Services

There is an active debate going on within the peer community as to how best to maintain the purity of peer support and whether peers should only work within peer-run organizations that have contractual relationships with more traditional services and systems.

As stated earlier, there is emerging evidence that peer support delivered by freestanding peer-run agencies are effective in fostering positive outcomes like decreased use of emergency and inpatient services.

At the same time, may believe that peers who are embedded within traditional systems can work as change agents to bring about true cultural transformation in those systems.

This, of course, brings up the fear that peers working within a traditional behavioral health agency will be co-opted and speaks to the need for administrative and frontline support staff training in non-peer environments.

In order to be an effective advocate for the people they serve, it is essential that peer staff have the ability to, at times, advocate to change the operating procedures or activities of the agency

they are working for without fear of censure or losing their jobs. This scenario is frequently played out with peers working within crisis facilities inpatient environments, and treatment agencies.

It is the very nature of advocacy to speak out on behalf of another despite predominant opinions and policy.

Jeanie Whitecraft, at the Institute for Recovery and Community Integration of the Mental Health Association of Southeastern Pennsylvania (MHASP) states, "When the environment is well prepared and has a structure for the sustainability of a well-trained recovery-oriented workforce, there will be no danger of peer support being co-opted into traditional business as usual".

The pressure to conform to the opinions of traditional professionals or systems is one of several key factors in the difficulty of retaining high quality peer support employees. It is extremely important that we establish clear definitions about the roles of peers in the work place with professional standards. This necessitates well written job descriptions, appropriate supervision models and independent peer support for those of us working in peer support roles

Peer Support from Peer-run Agencies/Recovery Community Organizations

Agencies run and staffed by people in recovery typically offer and embody the greatest fidelity to what is deemed to be "true peer support". There is growing evidence to demonstrate that services operated by peer-run agencies get the best results. Using this model provides sustainable support for the worker in a way that may not be possible in a traditional agency. Key elements of what constitutes a peer-run agency:

- At least 51% of Board members must be peers.
- All boards of authentic peer-run organizations must have a quorum of peers for voting purposes.
- Peers must hold the majority of staff positions.
- Organizations that contract with a fiscal sponsor or fiduciary qualify as peer-run if the following conditions are met:
    - The program is staffed by a majority of peers, including all the leadership and program management positions; peers supervise all non-peers.
    - All personnel decisions are made solely by the peer program.
    - All financial decisions, except those dealing with the administrative needs of the fiscal sponsor are made solely by the peer programs.

Many peer-run organizations employ peer support workers and provide supervision and support but sub-contract their services out to a variety of other agencies, such as:

- Community Mental Health Centers

- Managed Care Companies
- State agencies
- Emergency Rooms
- Hospitals
- Jails and/or prisons

Peer-run Agency Service Innovations
Over the past 20 years, peer-run agencies from across the nation have created a rich array of new program innovations: Please See Page 20 for Program And Staff Job Description Data

- **Peer Wellness Coaches or Whole Health and Resiliency Peer Specialists**
- **Addiction Recovery Coaches or Mentors**
- **Peer Bridgers**
- **Peer-run Crisis Respite Programs**
- **Peer-run Crisis Warm Lines**
- **Peer Crisis Support staff within Emergency Rooms**
- **Peer-staffed Living Room programs**
- **Peer Advocates**
- **Recovery and/or Wellness Center staff**
- **Peer-Run Supported Housing (Mental Health)**
- **Recovery Residences (Addiction Recovery)**
- **Peer-Run Employment Support/Coaching Services**
- **Self-Directed Care Brokers**
- **Forensic Peer Specialist:**
- **Certified Family Support**
- **Veteran Peer Specialists and Peer Support Technicians**:
- **VA Community Integration Specialist:**
- **Firestarters**
- **Promotoras – Bilingual Peer Specialist**

Building Systems to Manage the Business End of Peer-run Services
As peer-run organizations grow and take on contracts to provide peer support services in a variety of settings it becomes important to ensure that the infrastructure grows accordingly. Most peer-run agencies start off fairly small, but can quickly grow larger when contracted by funders to provide peer support to larger organizations.

When such growth happens, in order to uphold its' mission, quality, and standards, peer-run organizations need to develop sufficient infrastructure to support a wide range of new or increased responsibilities.

These include, but are not limited to:

- Billing
- Personnel/Human Resources
- IT & Data Management
- Marketing
- Contracting
- Consulting & Tech Support
- Payroll
- Accounting
- Legal
- Communications
- Suppliers & Procurement

During the growth of a company it is not unusual for all of these functions to be necessary but the organization may lack capital, space, skills, or other resources necessary. Some agencies choose to work with a Management Services Organization (MSO), which provides management services to a number of smaller companies at a lower cost than if the companies filled all of the required services on their own. The individual agency can pay on a flat monthly basis, per transaction, or pay-as-you-go basis, or a "fair share" basis based on size, revenues, numbers of employees, or number of persons served basis.

There are specialty provider networks like behavioral health Administrative Service Organizations (ASOs) that are set up specifically to work in the behavioral health field. These can be especially useful when contracting with managed care organizations or state agencies that require a significant administrative burden.

Some organizations choose to contract for their employees through a management organization. This often provides the employees with better benefits because they are actually employed by a larger organization.

Not all peer-run groups choose to utilize these types of services and are able to control their growth to keep pace with their needs. Whatever path an organization chooses it is important that they maintain an infrastructure that can fully support the business they take on. Peer-run organizations are almost always started and initially run by people who are cause driven but don't necessarily have prior business experience. It is critical to success and longevity that the leaders acquire the needed skills and employ qualified people to perform the specialized work involved.

Peer Support in Non-Peer-run Agencies and Settings

Traditional mental health care workers and agencies often have concerns about the use of peer support within their organizations. Some of these questions relate to insufficient understanding of the nature of recovery and about the roles that peers can play in a behavioral health system of care.

In contemplation of bringing peer specialists into private practice and clinics, and convincing health insurance companies of the efficacy, quality, outcomes and cost reductions achieved, many questions arise from staff. Education and training the staff to work with peers is an important starting place to begin the process.

When the peer specialist workforce began to expand in public behavioral health systems these same concerns were expressed frequently.
In contemplation of bringing peer specialists into private practice and clinics, and convincing health insurance companies of the efficacy, quality, outcomes, and cost reductions achieved, many questions arise from staff. Educating and training the staff to work with consumer/professionals is an important starting place to begin the process.

As the peer specialist workforce began to expand in public behavioral healthcare systems these same concerns were expressed frequently, but were quickly answered as the peers were brought into staff positions. Some of the typical concerns are:

1. **Question:** Are boundary issues more prevalent when using peer support services or does the practice require different boundaries that are not normally recognized by traditional providers?
   Answer: Peer providers require a different set of boundaries that recognize the different roles that are provided by CPS's when compared to traditional providers.
2. **Question:** "Is mistrust a significant issue between peer provider employees and their supervisors?"
   Answer: At the onset of hiring peers this may be true, but when traditional staff members are trained to work with CPS's and when the effect of their use is examined, mistrust is removed from the workplace." Chinman, M. et al (2012)
3. **Question:** Is an individual who has received services from the same clinic they now work for more likely to not be trusted by the traditional staff.
   Answer: As staff becomes more familiar with the assets that a qualified CPS brings to the practice and observes their professionalism and trustworthiness, these concerns will dissipate.
4. **Question:** Can peer support staff fulfill valuable roles in the treatment and support of the people being served?

Answer: While most peer specialists do not have advanced degrees, they do have experience as mental health service consumers, and this experience makes them uniquely qualified to serve as recovery role models and provide services to other consumers in ways that are different from non-peer providers. Chinman, M. et al (2012)

5. **Question:** Are peer specialists likely to relapse?
   Answer: "Relapse among PS's is rare. This is mainly because PS's who are hired have already demonstrated that they can handle job stress." Even if they do have a relapse they should be treated like any other employee who has a serious illness that interferes with job performance. Chinman, M. et al (2012)

Some staff consider any unusual behavior of peer support workers as symptoms of illness or relapse instead of recognizing it as reactions to stress that may be shared with non-peer workers. Frequently there is initial mistrust of peer workers to maintain confidentiality about behavioral health records. People with lived experience with psychiatric disorders, addictions and social stigma have a great appreciation of the importance of confidentiality. Generally, all of these questions are resolved when people work side by side with peer support workers, but it is important to provide staff training when preparing an agency for hiring peers.

It is critical that clear job descriptions are provided for all peer support provisions. It is necessary for the hiring process in choosing individuals with the right skill set and experience needed for the position, it is necessary for the employee to have a clear understanding of their job requirements, reporting responsibilities, and salary structure, and it is important for the creation of meaningful supervision and evaluation models.

The job description should define the position being hired and should detail the essential functions of the job. The agency should identify the purpose of the position in order to list the essential tasks and responsibilities required to perform the role. The description should list the knowledge, skills, and abilities needed, including the requirement that the individual must be stable in their recovery, and a current or former recipient of services. Training and certification standards should be listed, as well as age and education requirements. Jorgenson, J., (2014)

Salaries and benefits should be commensurate with other positions with similar levels of responsibility and training, and there should be a clear career ladder for peer employees to build meaningful careers in behavioral health. Some peer employees will seek full time employment with benefits while others may prefer part time positions either because of stress management, maintaining disability benefits, or the need for gradual return to full time employment.

SUPERVISION IS KEY TO FIDELITY AND OUTCOMES

Supervision is critical in this program in that not only does a professional need to oversee the program but also in the sense that supervising a peer specialist is different than other behavioral health positions. A peer specialist is able to work with an individual in a relationship that is based on having experienced similar issues in their own lives. Standard clinical boundaries frequently don't apply, and clinical supervisors and other staff, especially those who lack peer experience, may have expectations that are not compatible with the peer's role.

Often community mental health centers and addiction treatment agencies have supervised and evaluated peer specialists based upon the criteria used for case management. These two roles are very different and therefore require a different set of evaluation criteria.

Often, funding sources for peer services will require clinical supervision by another mental health professional as defined by the state. While clinical supervision can be highly beneficial in maintaining high standards of care, it is critical that the supervising professional understand recovery and the unique skills and assets provided by peer workers. Another peer in recovery who meets the state or funders standards to provide supervision is a good choice in supervising peer support workers. Additionally, the supervisor should be involved in the hiring process.

Supervision should be comprehensive, regularly scheduled, and meaningful to the person being supervised. Supervisors should schedule regular meetings with the individual and should be accessible to them for consultation at all times during the work day, when possible. Supervision is especially import early in the peer workers tenure in that it can smooth the transition into the position. Clinical supervision should include issues of job role clarification, performance, confidentiality, disclosure, working with other staff, boundaries and others as they arise. Effective supervision should be strength based and should focus on skills and professional development. Jorgenson, J., (2014)

In many settings administrative supervision may be necessary separate from clinical supervision. This may involve the setting of work duties, time management, administrative record keeping, and human resources roles including benefits management and complaints and grievances. As in any HR department, administrative supervision should be aware of reasonable accommodation needs and standards. It should support ongoing education and training, particularly when required for recertification or job requirements. Jorgenson, J., (2014)

According to Jeanie Whitecraft, "Human Resources departments are key to creating policy, procedures and a structure to ensure that recovery-oriented principles are carried out. This is very important in a system that has a high staff turnover. One cannot assume that all new employees have knowledge of recovery and an understanding of the effectiveness of peers working in the system of care.

Peer support services are a “new role” in the mental health system, not a “special position.” Peer support is a role that complements the work of the system, not one that competes. The supervisor’s role is one of leadership that has a clear understanding of each staff member’s role and principles of recovery in order to provide support and guidance. Supervisors are key to the smooth integration of peers on the team and integration into the workforce of recovery-oriented practices. Supervisors are instrumental to the checks and balance of a recovery-oriented practice.”

NASMHPD’s publication, Enhancing the Peer Provider Workforce: Recruitment, Supervision and Retention lists comprehensive guidelines for supervision models for peer support employees. Jorgenson, J., Schmook, A. (2014)

Annual or periodic evaluations are not only necessary; they are the right of the employee. This is the way that people understand and get or give credit for job performance. It is often directly linked to raises and promotions. Effective evaluations should be closely linked to job descriptions and standards.

Mentoring can be a formal or informal relationship established between an experienced, knowledgeable employee and an inexperienced or new employee. “The purpose of the mentoring relationship is to help the new employee quickly absorb the organization’s cultural and social norms.” Mentoring also assists an employee, new to a specific job or area of responsibility, to quickly learn what they need to know to succeed in their job and the clearly defined roles of the positions. Human Resource Management Glossary (2014)

Organizations that want to maximize the use of knowledge-based employees will need to shift to a consultative and participative management style, usually referred to as coaching. This requires managers to transition from the traditional role of controlling and monitoring employee performance to a more consultative role. Coaching is a way to develop a partnership between the manager and employee and creates a shared understanding about what needs to be achieved and how it is to be achieved. Johnson, A., (2014). Coaching is particularly effective with peer supporters because they function as coaches in the performance of their peer support roles.

Retention of capable peer supporters has been an ongoing problem for many agencies. This is the result of many factors; in many areas of the country pay rates for peer support are minimal and offer little room for advancement. In many organizations and even government agencies peers are hired as contract workers and receive no benefits. Frequently there is little positive feedback about the work of peer supporters from their agencies and colleagues, resulting in low morale and low job satisfaction.

It is important to include peer support employees as full members of the care structure and that they are included in team meetings and planning. While peer supporters are change agents within the agencies they work in, it is still vital that management provide training and education for other staff to change the culture of low regard for anyone living with psychiatric disorders or addictions that are so prevalent in the industry.

Peer support workers may need flexible and reasonable accommodations in the workforce and Human Resource departments should be knowledgeable and prepared to work with them as needed. These accommodations should not present barriers to career advancement or hiring. The Americans with Disabilities Act is a powerful law that protects workers with disabilities.

One of the primary reasons for low morale is frequently the result of lack of clarity about job expectations, improper supervision, and impractical evaluation methods. Another important issue is the need for support for peers in the workplace. Having more than one peer support employee provides the opportunity for mutual peer support, and information should be available to the employees about outside peer support groups. Many locals have developed peer specialist support groups for that purpose.

POSITIONING PEER SERVICES WITHIN NEW HEALTHCARE DESIGNS

National and state healthcare reforms are seeking and supporting service reimbursement designs that effectively, efficiently, and accountably advance the goals of wellness and recovery, prevention, diversion, healthcare, and community inclusion. Accordingly, states are increasingly moving from separate fee-for-service based systems to integrate medical and behavioral healthcare via fully integrated Medicaid managed care designs. Key principles of these designs include:

- Prevent rather than treat
- Intervene earlier rather than later
- Intervene with populations rather than persons
- Always assess effects of interventions

Increasingly states are reorganizing care through the creation of "health home" provider networks that integrate medical and behavioral healthcare, housing, and social services to advance health outcomes and address the broader spectrum of factors often called the "social determinants of health".
It is expected that peer supporters will:

- Play key roles in integrated health homes, rather than in separated specialty settings.
- Be engaged in disease prevention and health promotion activities.
- Be working directly with communities and populations, not just individuals.
- Be emerging leaders in many different roles

As a result peer supporters will be serving to

- Organize and deliver community interventions that reduce trauma.
- Organize and deliver community interventions that promote good health
- Organize an integrated community health collaborative that promotes the wellbeing of entire communities.

States are pursuing more flexible Medicaid funding designs that allow them to pay for peer service expansions via a variety of waiver, grant, and program dollars. These can include the adoption of the 1915i Home and Community Based Services option or waiver, self-directed initiatives in which the individual controls their behavioral healthcare budget, and/or the adoption of managed care initiatives for those who are dually eligible for Medicaid and Medicare.
In fact:

- 47 states have comprehensive managed care programs.
- In July 2011, CMS calculated that over 74% of all Medicaid beneficiaries received some or all of their services through capitated and non-capitated managed care arrangements.

- Twenty five states have started new programs for people who are dually eligible for Medicare and Medicaid services using a risk-based managed care model. 47% of Medicaid recipients are in risk based plans where the MCO receives a capitated rate to serve the designated population and is "at risk" for all or part of any cost overruns. National Council on Disability (2014) www.ncd.gov

In some states, peer services have become required offerings within their Medicaid managed care benefits packages. Some states offer financial incentives for the expansion of peer-run services.

Many are working to advance and improve the peer workforce via training and education, certification, and leadership development. Some are considering the establishment of an accreditation for peer-run agencies.

Peer service innovations can play unique and crucial roles in improving systems of care, enhancing healthcare outcomes and reducing costs through their expertise in:

- Outreach and Engagement: starting where the person is, both in terms of what their immediate concerns and needs are as well as locating where they live or can be found.
- Person Centered and Directed Care: enhanced by recovery centered tools like Recovery Capital Assessments and Recovery Plans, Wellness Recovery Action Plans (WRAP), Psychiatric Advance Directives and Self-Directed budgeting initiatives.
- Increasing Health Literacy and Self-Management: via tools like the 8 Dimensions of Wellness and whole health initiatives. This is critically important given the often repeated finding that people diagnosed with mental illnesses die 25 years earlier than the general public due to a combination of factors, including:
    - Heart disease
    - Cancer, often related to high percentage of people with psychiatric disorders who smoke
    - Suicide
    - COPD
    - Hypertension associated with obesity
    - Diabetes
    - Poverty
    - Idleness and isolation
    - Hopelessness and shame
- Relapse Prevention and Crisis Management Supports: including peer crisis diversion, WRAP, respite, and support programs.

- Transitional Supports: including peer bridger services that assist individuals to make successful transitions from inpatient settings, detox, jail or prison, and adult or nursing homes.
- Addressing the Social Determinants of Health:
    - Income, employment, and education
    - Housing, social support
    - Trauma, early childhood experiences
    - Social exclusion, discrimination, marginalization
    - Lack of access to resources

There is an increasing body of evidence about the effectiveness and cost-effectiveness of peer-run services, most notably

- Optum is showing a 24-47% decrease in overall healthcare utilization for members using peer services
- Connecticut Community for Addiction Recovery is reporting that approximately 83% of individuals maintain sobriety while receiving peer coaching services.
- Reduction in re-hospitalization rates RECOVEReworks (2014) Bergeson, S. (2011) Optum Health (2011)

"With the introduction of ACA, peer providers will continue to expand their role in the delivery of mental health services. ACA specifically includes resources for peer involvement through provisions for Community Health Workers (CHWs) Peers for Progress, (2002). ACA defines CHWs as individuals who promote health or nutrition within the community in which they reside by:

- Serving as liaisons between communities and health care agencies• Providing guidance and social assistance to community residents
- Enhancing community residents' ability to effectively communicate with health care providers Providing culturally and linguistically appropriate health and nutrition education
- Advocating for individual and community health
- Providing referral and follow-up services or otherwise coordinating care
- Proactively identifying and enrolling eligible individuals in federal, state, and local private or nonprofit health and human services programs (H.R. 3590). Organizations can leverage the financial mechanisms available for CHWs by incorporating peers who have received specialized training and who use their recovery journey to support other consumers." Tobias et al (2010), Dickerson, G. (2014)

STATE LEVEL ADVOCACY TO BEST POSITION PEER-RUN SERVICES

Many states are now looking to the managed care industry to provide behavioral health service through Medicaid funding. Previously, providers billed the state Medicaid authority directly upon delivery of services on a "fee for service" basis. In the managed care system, providers are under contract with the MCO to determine, along with the person receiving services, what is the appropriate course of treatment. Adler, D., et al (2010)

Managed care companies are looking for behavioral health services that promote recovery and resiliency. In some cases they are even encouraging peer-run organizations to be even more progressive and innovative in the services they offer. In 32 states Peer Support Services, having been recognized by CMS as an evidence based practice, are billable to Medicaid.

Advocates for expanded recovery services that can be funded by Medicaid can educate and support their states to adopt the most flexible form of Medicaid, the 1915.i Home and Community Based Services Option or Waiver.

This program allows Medicaid funding for services that have been frequently paid for in small state grants, or contracts. These typically include:

- Psychiatric Rehabilitation
- Peer Support/Drop-in Centers
- Certified Peer Specialists
- Bridger/Peer Link Programs
- Employment Services
- Housing Services
- Respite
- Specialty Programs/Services
- Young Adult Transition Support Services

Adler, D., et al, (2010)

Advocacy for adoption of the Home and Community Based Services can involve state Medicaid, behavioral health agencies and the Governor's Office.

For example, a New York State-based group of peer-run service providers played a central role in getting state Medicaid reforms to include the following language

- "Peer services should be incorporated into the new behavioral health specialty managed care system.

- Medicaid funding will be sought for peer services through waivers, grants, and program funding.
- Advance and improve the peer workforce through funding for training and education, certification, and leadership development, as well as through the establishment of an accreditation process for peer-run agencies.
- Peer services will be incorporated into Health Homes"

State defined outcome measures play critical roles in defining the requirements that health and behavioral healthcare systems must meet in order to get reimbursed. In another example, New York, advocates were able to get 'involvement with peer-run services' as a new requirement of emerging healthcare systems.

Finally, advocates should work to see that states reinvest savings from decreased use of costly inpatient and emergency services into the expansion of community recovery services, including peer support. In New York, the following language was inserted into state healthcare reform requirement: "reinvestment should be focused on high priority areas, including housing, employment services, peer services, and family support." Medicaid Redesign Team Behavioral Health Reform Work Group (2011)

PREPARING PEER-RUN ORGANIZATIONS TO CONTRACT WITH MANAGED CARE ORGANIZATIONS AND TO BILL MEDICAID

In order to contract with managed care companies, most peer-run organizations will need to look closely at both their administrative support staff capacity and their financial staff support capacity. You must have enough staff to provide the MCO's with the kinds of records and reports they will be seeking. Your financial staff must be knowledgeable enough to bill and document the managed care organization for the services you provide. This is the time when some organizations choose to work with a management services organization in order to meet the requirements of contracting with a MCO.

Because of long lag times between billing and payment, peer-run organizations must have sufficient financial strength to pay for services, administration and financial services prior to payment. You should be prepared for up to a six month lag between billing and payments. In some instances it is possible to negotiate a contract that provides an advance payment at the onset of the contract. This can be essential to many peer-run organizations (PROs) in their first year of contracting with managed care. It is critical that PROs hire staff to meet demand rather than hoping that demand will meet your increased staff. Adler, D., et al (2010)

Remember, if you contract with a MCO to provide Medicaid services you must meet all of the state and federal laws that apply. There is always the potential for heavy fines or even jail time if your organization does not comply and maintain clear records. Your organization will be held to the same standards as any other provider and therefore must conduct business just as professionally.

Optum Behavioral Health has provided the following checklist to use with your board when considering a contract with a MCO:

Checklist	**Yes**	**No**
Does our organization agree with the concept of increasing the use of community based services and, therefore, decreasing unnecessary hospitalizations?		
Is our organization seeking ways to help break the cycle of illness and move to wellness?		
Do we believe we will learn something that will help us advocate on behalf of those we serve by being part of a managed care network?		
Can we commit to remain advocates despite being a part of an MCO network?		
Can we see ways our organization can help an MCO learn to be more		

recovery and resiliency oriented by being a part of a network?		
Do we have a program or service that would help decrease unnecessary utilization, increase adherence and/or outcomes?		
Is there research we can point to that supports the benefits of services we have to offer?		
Do we have enough administrative staff to handle the paperwork?		
Do we have enough financial staff to manage the billing?		
Do we have reserves enough to sustain us before receiving reimbursements?		
Do we have sufficient staff to manage the contract without adding staff?		
Can we guarantee enough business to make adding staff an economically sound decision to make?		
Can we meet the terms of the contract within the time frames specified?		
Are our systems secure enough to handle the privacy requirements?		
When taking into consideration the costs of new administrative, finance, and/or program staff along with any upgrades needed to equipment, will we still have a return on our investment based on the predicted referral volume?		
TOTALS		

Adler, D. et al (2010)

When managed care companies are considering adding a peer-run organization to their network, they look for:

- Benefits to those receiving services
    - Knowledge of the system and experience in navigating it.
    - Easier engagement because of lived experience
    - Role models because of success in personal recovery
    - Knowledge of coping strategies, experience with medications, and lessons learned in recovery.
- Benefits to peer provider
    - Empowerment of provider and increase in self-value and esteem.
    - Opportunities for growth and development
    - Sustainability
- Benefits to MCO
    - Provider can educate and heighten staff awareness and sensitivity to struggles faced by consumer/families
    - A different perspective that brings understanding and diversity to the organization.

- Increase in the likelihood that the consumer voice is integrated in planning, evaluation and delivery of services.
- Provider may help fill a gap in service delivery, especially for people with severe psychiatric disorders.
- Transformation to the system of care
- Provider can offer innovative and creative alternatives or enrichment to traditional services.

MCO's look for three key factors in network participation:

1. Assuring high quality of services that are compliant with state and federal requirements.
2. Assuring services achieve positive, measurable results.
3. Supporting the principle of health care affordability, which results in a cost-effective approach to services.

Many states are including requirements in managed care contracts for covering peer support as a distinct service in Medicaid programs. Many managed care companies have adopted the recovery/resiliency model as the basis for much of the services they deliver to individuals receiving care. Peer-run organizations are utilized to teach social and coping skills essential to increasing resiliency and providing a model for recovery. These are some of the factors driving MCOs to consider contracting with peer-run organizations.

The steps in MCOs contracting with peer providers

- Confirm a network need for the services and supports offered by the peer-run organizations
- Complete application and paperwork necessary to participate, including credentialing.
- Credentialing is organized by provider type and level of care with specific criteria for each type and level. Providers must comply with safety and privacy requirements under law.
- Contract negotiations. In some instances reimbursement rates are negotiable.
- Maintain copies of all paperwork (contracts and applications) and confirm that all necessary information is correctly loaded into the information system to support referrals and claims.
- Participate in information forums and trainings. Generally the MCO will provide technical assistance through trainings to explain procedures.

Things Peer-run Organizations Need to Have in Place:

- Completed application and acceptance letter
- List of all locations and hours of operation
- Copy of certifications and/or licenses
- Copy of General and Professional Liability Proof of Insurance
- Tax ID or Social Security number
- Medicaid number
- Copies of CVs or resumes
- Copies of background checks
- List of references
- Resources to ensure delivery of quality care in an appropriate and timely manner.
- Participation in ongoing training to increase knowledge and skills.

Adler, D. et al (2010)

How Peer Providers Get Paid

Providers are paid based on a negotiated rate included in their provider agreement. Claims must be filed using proper forms, codes, and on a timely basis. Check with the MCO's you provide services to for their requirements.

Make sure that you meet established service limits for the type of service billed. (For example, some types of services might be limited to 15 minute sessions 4 times per day/week/month. Follow all pre-authorization requirements, and ensure that any benefits coordination issues are addressed, such as dual eligibility.

Enrollment into services

MCO's and Medicaid have very specific enrollment procedures that document that the client is receiving a necessary service. Peer providers must be careful to adhere to the contracted enrollment process or face pay backs and/or fines.

Data Collection

Working with Medicaid managed care requires the collection and storage of significant amounts of information. It is essential to understand the requirements and verify that you have sufficient staff, equipment, and software to satisfy them prior to contracting with a MCO.

Quality assurance and improvement

As your agency grows to meet the needs of managed care you will want to constantly monitor the effectiveness and quality of the services you are providing and have the flexibility to adapt them for improvement on an ongoing basis. An important part of designing a quality service is building in an evaluation process that gives you measurable indicators about success and guides you in program improvement.

Utilization management (UM) is defined by the Institute of Medicine (IOM) Committee on Utilization Management by Third Parties (1989) as "*a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision*" Field, M. J. (1989)

Technology Readiness

In order to accomplish nearly all of the requirements of contracting with managed care, billing, data collection, record keeping, quality assurance, communications, and utilization management, it is important that you are technologically prepared. This can require significant investment in equipment, software, and staff. Managed care companies can be very helpful in understanding the degree of sophistication required prior to contracting.

Marketing

Initially, for most peer provided organizations, marketing is not a major issue but as your organization seeks to grow it becomes important to market both your services and your organization. Social media and web based promotion are now essential parts of any marketing plan, so it is important to have staff members who are knowledgeable in these areas even if you utilize outside marketing services.

Evaluation Criteria for MCO's

Contracting with provider agencies, state authorities, and managed care companies will require you to monitor a number of factors to meet their standards; these will be provided to you by the agency. As a peer-run agency you should also be evaluating the results of your services based on whether or not those services improve the quality of life of those receiving them. Are people's lives actually getting better because of what you do?

Two excellent surveys are the Personal Outcome Measures (POM) survey and the Recovery Oriented Systems Indicators (ROSI) survey. Personal Outcome Measures focuses on the choices people have in their lives and serves as a powerful tool for evaluating the quality of life for people and the degree to which organizations individualize supports to facilitate those measures. The ROSI looks at systems of care and quality of life issues including: person-

centered decision-marking and choice, invalidated personhood, self-care and wellness, basic life resources, meaningful activities and roles, and peer advocacy.

There are several useful measurement tools available, here is a partial listing:

- Personal Outcome Measures, Council on Quality and Leadership, (2012)
- Recovery Oriented Systems Indicators, (ROSI*),* Dumont, J. M., et al. *(2005)*
- Community Integration and Measuring Participation Salzer, M., Baron, R. C., (2006)
- Community Participation as a Predictor of Recovery-Oriented Outcomes Among Emerging and Mature Adults with Mental Illness. Kaplan, K., Salzer, M., & Brusilovsky, E. (2012).

There are a variety of other outcome measures for people receiving peer support that are important to follow:

- Re-hospitalization rates compared to individuals not receiving peer support
- Changes is engagement rates for people in traditional services
- Number of outpatient services accessed
- Overall satisfaction with services
- Length of time people remain in traditional services
- Improvement in quality of life and other wellness measures

EXPANDING PEER SUPPORT INTO PRIVATE PRACTICE

Peer support in behavioral health has blossomed throughout the public sector but, so far, it has not taken on a major role in the provision of care in the private behavioral healthcare system. At the same time the medical community has begun to shift to the concept of whole health care, in which medical clinics provide services for traditional physical health needs and services for behavioral health care. Ultimately this will become a standard for the industry. Many primary care centers have brought psychiatry and psychology into their practices and many behavioral health care centers have hired primary care physicians as members of their staffs. The medical community has begun to embrace the concepts of, integrated care, recovery, resiliency, and wellness in the behavioral health care system.

Over the last 20 years the "peer" workforce has multiplied rapidly, there are now thousands of behavioral health peers working in a number of positions in the public behavioral health care system. Most of these workers have been trained and certified by their states as Certified Peer Specialists or Peer Recovery Specialists.

Unfortunately, one of the key aspects of behavioral health recovery, peer supports and services, has made little headway in becoming part of the private behavioral health care system. Much of this is due to a lack of understanding of the nature of recovery in behavioral health, and fundamental misunderstandings of the role of peer supporter workers. The type of support services that peers can provide help keep people out of more expensive deep end services like crisis care and hospitalizations. Peer support services are evidence based practice. CMS, (2007) Private health insurance companies and the private behavioral health care system need to be shown the outcomes for people who receive peer support services and the cost savings attained by keeping people out of critical care such as hospitals and crisis units.

THE FUTURE OF PEER SUPPORT

Peer support is a rapidly growing field. Research continues to show that it is efficacious and cost effective. State and local agencies, managed care companies and private practice and insurance are utilizing peer support more each year. The potential for the peer workforce is tremendous, especially as we begin to develop clear career paths and equitable pay scales for peer workers. It is inevitable that peer support will continue to grow throughout public and private behavioral health. Organizations like Mental Health America intend to introduce accredited national certification for enhanced peer support skills.

"Peer recovery support services (PRSS) can be successfully integrated with professional models of care (e.g., blended and sequenced in ways that potentially magnify the catalytic potency of each). This can occur at all levels of behavioral healthcare systems, but such integration requires planning, education, and support for peers and professionals as well as education of the larger community about the role and value of PRSS." White, W. L. MA, Evans, A. C. Jr. PhD (2014)

"A new generation of peer helpers is working in volunteer and paid roles within new grassroots recovery community organizations, within addiction treatment programs, and within such allied fields as primary healthcare, child welfare, and criminal justice. This trend reflects not a rejection of scientific knowledge and professional treatment, but an effort to integrate addiction science, cumulative clinical experience, and knowledge drawn from the lived personal/family experience of addiction recovery." White W. (2014)

"The future of peer support is the future of transformation and positive outcomes. There is a lot of work yet to be done to sustain the recovery paradigm shift, and we need to get out there and keep a "seat at the table" so we don't lose ground.

Environmental readiness is a key to the future of a successful, recovery-oriented system of care and the successful integration of peer support in the workforce. Environmental readiness is not just a one-time training of the workforce; it is an ongoing process of holding agency employees accountable for moving recovery principles into practice. Establishing a recovery-oriented culture of services and supports is complicated, and starts with leadership "buy-in" and an internal change in the management team within each provider agency. Assisting individuals in recovery and program personnel to understand and embrace the recovery philosophy and orientation will require a concerted effort by all stakeholders.

I believe that moving from principles to practice is a highly effective model and can become transformational not only at work but in life. At the end of the day, it's about "social change": a cultural shift. As behavioral health service providers, we need to look at our own behaviors. Moving from principles into practice is not something you can put on like a hat when you come

to work, and our willingness to fully embrace recovery principles can help to shape real change." Whitecraft, J. (2014)

The danger, which is already recognized by many of our leaders, is losing the essential nature of true peer support as we professionalize the field. That is not to say that it can't be professionalized and maintain its' nature, the fact is that it is already being done. Peers encompass the full range of professional skills and still bring something completely unique to the table, the essence of lived experience.

REFERENCES & RESOURCES

Adler, D., Bergeson, S., (2012) The Next Step to Sustainability: Guide for Family and Consumer Run Organizations Seeking to Expand Their Funding by Becoming a Part of a Managed Care Network, Optum Health, Public Sector,

Adler, D., Bergeson, S., Brown, M., Fox, P., (2010) The Next Step to Sustainability: Guide for Family and Consumer Run Organizations Seeking to Expand Their Funding by Becoming a Part of a Managed Care Network, Optum Health, Public Sector,

Betty Ford Clinic (2007) http://www.bettyfordcenter.org/recovery/methods-techniques/betty-ford-institute.php

Bergeson, S. (2011) Cost Effectiveness of Using Peers as Providers.

BRSS TACS, (2012) Equipping Behavioral Health Systems & Authorities to Promote Peer Specialist/Peer Recovery Coaching Services, SAMHSA Bringing Recovery Supports to Scale.

Campbell, J., Leaver, J. (2003) Emerging New Practices in Organized Peer Support. National Technical Assistance Center for State Mental Health Planning and National Association of State Mental Health Program Directors.
http://www.nasmhpd.org/docs/publications/archiveDocs/2003/peer%20support%20practices%20final.pdf

Chamberlin, J., Rogers, S., Ellison, M. (1996) Self-Help Programs: A Description of Their Characteristics, and their members. *Psychiatric Rehabilitation Journal*, Vol. 19, No. 3), pp 33-42

Chinman, M., Henze, K., Sweeney, P., McCarthy, S. editor. (2012) Peer Specialist Toolkit: Implementing Peer Support Services in VHA. VISN 1 New England MIRECC Peer Education Center, VISN 4 MIRECC Peer Resource Center.
http://www.mirecc.va.gov/visn4/peer_specialist_toolkit.asp

Clearinghouse Self-Help Group Sourcebook. Chapter 5, 1-16.
http://www.cdsdirectory.org/resources.html

CMS. Letter to State Medicaid Directors. Center for Medicare and Medicaid Services, Center for Medicaid and State Operations. (2007), SMDL #07-011

Cook, J., Copeland, M., Corey, L., Buffington, E., Jonikas, J., Curtis, L., Grey, D., Nichols, W. (2010) Developing the Evidence Base for Peer-Led Services; Changes Among Participants Following Wellness Recovery Action Planning (WRAP) Education in Two Statewide Initiatives. *Psychiatric Rehabilitation Journal* 34(2):113-20

Council on Quality and Leadership, Personal Outcome Measures. (2012) http://www.thecouncil.org/pomindex.aspx

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., and Tebes, J.K. (1999) Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*. 6 (2) 165-187.

Depression, Bipolar Support Alliance. Learn about Peer Specialists. (2014) http://www.dbsalliance.org/site/PageServer?pagename=education_training_learn_about_peer_specialists

Dickerson, G., Integrating Peer-support Services with Healthcare Reform, Homeless Resource Center. SAMHSA. (2014) http://homeless.samhsa.gov/resource/integrating-peer-support-services-with-health-care-reform-56161.aspx

Dumont, J. M., Ridgway, P., Onken, S. J., Dornan, D. H., Ralph, R. O., (2005) Recovery Oriented Systems Indicators Measure (ROSI) The Evaluation Center @ HSRI, http://www.power2u.org/downloads/ROSI-Recovery%20Oriented%20Systems%20Indicators.pdf

Farrington, A. Peer Certification Identifying Core Competencies. Florida Certification Board, Tallahassee, FL 2011

Field, M. J. (1989). Controlling Costs and Changing Patient Care: the role of utilization management. National Academies Quality of Life Measurement Among Persons with Chronic Mental Illness: A Critique of Measures and Methods, Mark J. Atkinson, M., J., Ph.D., Sharon, Z., M.Sc., (2002)

Helpguide.org (2014) http://www.helpguide.org/articles/addiction/substance-abuse-and-mental-health.htm

Humphreys, K., Wing, S., McCarty, D., Chappel, J., Gallant, L., Haberle, B., Kaskutas, Kirk, T, Kivlahan, D. (2004) Self-Help Organizations for Alcohol and Drug Problems; Toward Evidence-Based Practice and Policy. Journal of Substance Abuse Treatment. 26, 151-158

Human Resource Management Glossary. (2014) http://humanresources.about.com/od/glossarym/g/mentoring.htm

Johnson, A., (2014) What is Coaching? Massachusetts Institute of Technology. https://hrweb.mit.edu/learning-development/learning-topics/leading/articles/what-is-coaching

Jorgenson, J., Schmook, A., (2014) Enhancing the Peer Provider Workforce: Recruitment, Supervision, and Retention, National Association of State Mental Health Program Directors (NASMHPD) Assessment #1.

Kaplan, K., Salzer, M., & Brusilovsky, E. (2012). "Community Participation as a Predictor of Recovery-Oriented Outcomes Among Emerging and Mature Adults with Mental Illness." Psychiatric Rehabilitation Journal, 35(3)

Kyrouz, E.M., Humphrey, K., Loomis, C. (2002) A Review of Research on the Effectiveness of Self-Help and Mutual Aid Groups." in White, B.J., Madara, E.J. (Eds.) American Self-Help

Lawn, S., Smith, A., Hunter, K. (2008) Mental Health Peer Support for Hospital Avoidance and Early Discharge: An Australian Example of Consumer Driven and Operated Service. Journal of Mental Health. 17(5) 498-508

Lucksted, A., Ph.D., McNulty, K., Brayboy, L., Forbes, C. (2009) Initial Evaluation of the Peer to Peer Program, Psychiatric Services, February, Vol. 60, No. 2

Mark J. Atkinson, M., J., Ph.D., Sharon, Z., M.Sc., (2002) Quality of Life Measurement Among Persons with Chronic Mental Illness: A Critique of Measures and Methods. http://www.phac-aspc.gc.ca/mh-sm/pubs/quality_of_life-qualite_de_vie/preface-eng.php

Mead, S. Defining Peer Support. (2003). Retrieved March 12, 2012, from http://www.mentalhealthpeers.com/pdfs/DefiningPeerSupport.pdf

Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations. (2011); 9, 11, 12, 44, 64 https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

McLean, J., Biggs, H., Whitehead, I., Pratt, R., Maxwell, M. (2009) Evaluating of the Delivering for Mental Health Peer Support Worker Pilot Scheme. Edinburgh; Scottish Governmental Social Research.

NAMI STAR Center. (2010) Cultural Competency in Mental Health Peer-run Programs and Self-help Groups: A Tool to Assess and Enhance Your Services. http://www.power2u.org/downloads/CulturalCompetencyInMentalHealthPeer-runProgramsSelf-helpGroups.pdf

National Practice Guidelines for Peers Supporters (2011) http://na4ps.files.wordpress.com/2012/09/nationalguidelines1.pdf

National Council on Disability (2014) www.ncd.gov

O'Hagan, M. (2010) Peer Support in Mental Health and Addictions: A Background Paper, The Kites Trust. http://www.peerzone.info/sites/default/files/resource_materials/Peer%20Support%20Overview%20O'Hagan.pdf

Optum Behavioral Health, Peer Coach, PowerPoint (2014)

Peers for Progress. Mental Health Peer Support: Effectiveness and Cost-Effectiveness, Peers for Progress: Peers Around the World, http://peersforprogress.org/pfp_blog/mental-health-peer-support-effective-and-cost-effective/

Peers for Progress (2002) Evaluate Peer Support. http://peersforprogress.org/take-action/evaluate-peer-support/

Peers for Progress. (2012) Accelerating the Availability of Best Practices in Peer Support Around the World. Retrieved from: http://peersforprogress.org/wp-content/uploads/2012/11/20121126_peers_brochure_updated_2013.pdf

RECOVEReworks (2014) Peer Support Services and the Changing Landscape: An Interview with Allen Daniels Ed.D., The Coalition of Behavioral Health Agencies, No. 99, January 2014

Salzer, M., Baron, R. C., (2006) Community Integration and Measuring Participation, http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/measuring_community_inclusion/CI_and_Measuring_Participation.pdf

SAMHSA (2012) *Equipping Behavioral Health Systems & Authorities to Promote Peer Specialist/Peer Recovery Coaching Services* http://www.samhsa.gov/recovery/docs/Expert-Panel-02112013.pdf

SAMHSA. (2005) Working Definition of Recovery. http://beta.samhsa.gov/sites/default/files/partnersforrecovery/docs/ROSCs_principles_elements_handout.pdf\

SAMHSA's *Guiding Principles of Recovery* and the findings of the *Recovery Support Strategic Initiative. (*2012) http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.VDVeCYmBHrc

SAMHSA-HRSA Center for Integrated Solutions, (2014) Peer Providers, http://www.integration.samhsa.gov/workforce/peer-providers

SAMHSA. (2009) What are Peer Recovery Support Services? Center for Substance Abuse Treatment. https://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf

SAMHSA (2014) Recovery and Recovery Support http://www.samhsa.gov/recovery

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, 27(4), 392-401.

Velicer, C. MPH. (2013) Mental Health Peer Support: Effectiveness and Cost-Effectiveness, Peers for Progress: Peers Around the World. http://peersforprogress.org/pfp_blog/mental-health-peer-support-effective-and-cost-effective/

Veterans Administration, (2013) Peer Specialist Toolkit: Implementing Peer Support Services in VHA. http://www.mirecc.va.gov/visn4/peer_specialist_toolkit.asp

White, W. (2009) Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services. http://www.naadac.org/assets/1959/whitew2009_peer-based_addiction_recovery_support.pdf

White, W. (2014) Power of Peer Support. Selected Papers, William L. White. http://www.williamwhitepapers.com/blog/2014/08/power-of-peer-support.html

White, W. L. MA, Evans, A. C. Jr. PhD. (2014) The Recovery Agenda: The Shared Role of Peers and Professionals. Public Health Review. Vol 35, No. 2; 3 http://www.publichealthreviews.eu/upload/pdf_files/14/00_White_Evans.pdf

Whitecraft, J. (2014) Personal communication. The Institute for Recovery and Community Integration, The Mental Health Association of Southeastern Pennsylvania.

Wikipedia (2014) Peer support specialist http://en.wikipedia.org/wiki/Peer_support_specialist#Training_and_certification

Appendix A
Core Competencies and Role Delineation Study

Core Competencies

As peer support expands throughout the behavioral health field it will become necessary for certifying agencies to utilize standardized methods for creating certifications that are accredited by a national authority to achieve credibility with health insurers and funding agencies. The Institute for Credentialing Excellence (ICE) defines the credentialing process as "a method for maintaining quality standards of knowledge and performance, and in some cases, for stimulating continued self-improvement. Credentialing confers occupational identity" (page 4, *Ice Guide to Understanding Credentialing Concepts.* Institute for Credentialing Excellence. 2005.) In order to "credential" a person in a profession, one must first be able to define the core competencies of the profession. If you do not know what the on-the-job expectations of a peer are, you cannot build a program to measure competency in the delivery of peer services. Correctly identifying core competencies is critical to the success of any program that seeks to discriminate between "those who know and can perform the job adequately" and "those who do not know and are unable to perform the job adequately."

It can be very tempting for the leaders in any field to "assume" that they know what needs to be done on the job – how else did they become a leader? However, bias can run rampant when the approach to identify core competencies simply involves a group of leaders and experts in the field, who gather together and list out core competencies. Although it may intuitively seem that "leaders and experts" will know what the core competencies should be, following this assumption tends to result in non-valid and non-reliable core competencies. Common dangers include:

- Personal beliefs and biases can influence identified core competencies.
- Emerging issues may be erroneously reflected in core competencies as more "important" or "critical" than they actually are.
- A disconnect may occur between what "should be done" and "what is actually being done" in the field.

In order to assure reliability and validity, it is critical that a recognized method to establish core competencies is followed. Further, all other decisions about competency standards – such as formal education requirements, content-specific training requirements, and on-the-job experience and supervision requirements must be directly linked to the core competencies. In short, if someone is being asked to complete specific requirements to earn a credential, the requirements need to be related to the core competencies of the profession.

- All training requirements should reflect core competencies.
- All testing instruments should measure the candidate's possession of core competency knowledge and skill.
- All on-the-job experience and supervision requirements must reflect what peers are doing on the job.

When core competencies are not correctly identified, all other program elements begin to crumble.

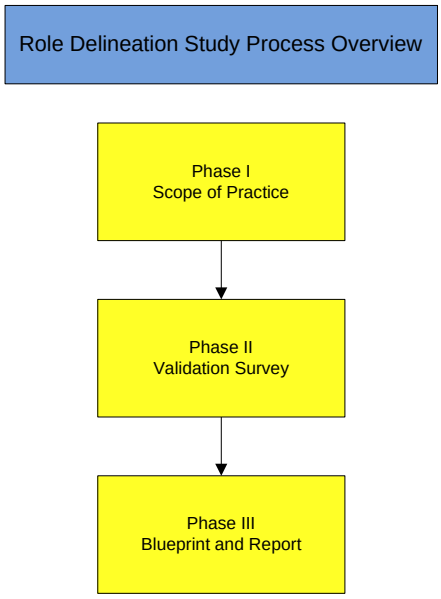

Figure 1-1

Role Delineation Study

In the instance that a new credential is being developed, the Role Delineation Study (RDS) starts with conceptualizing the targeted profession, followed by establishing the credentials standards and requirements. Best practice dictates that a RDS is updated at least every five (5) to seven (7) years.

The RDS is a three-phase process, as illustrated in figure 1.1. The first phase of the project focuses on the professions defined Scope of Service, which includes:

1. target audience characteristics/minimum requirements;
2. performance domains;
3. task statements; and
4. knowledge, skill, and ability (KSAs) statements.

The certifying agency can update the Scope of Service in a two-day, face-to-face workshop of 12 to 15 client identified subject matter experts (SMEs). The certification expert leads the SMEs through a series of individual, small group, and large group brainstorming, discussion and critical thinking activities, all focused on identifying the job tasks, knowledge, skills, and abilities of a peer. At the end of the meeting, a draft document detailing the recommended Scope of Service has been developed.

Though the SMEs possess advanced competency in the specified profession, they only represent a small portion of the total professional population. As such, the certification agency conducts a RDS Validation Survey Study to validate the recommended Scope of Service established by the original SME workshop participants.

The validation survey can be conducted over the internet. The minimum number of survey respondents is variable and is determined by the estimated number of incumbent

professionals. After the validation survey has closed, the agencies psychometricians analyze and interpret the survey data, including the demographic characteristics of the surveyed population, the mean importance and mean frequency ratings, as well as combined ratings, and obtain a reliability rating to establish whether the survey respondents' ratings are reliable for determining exam proportions for each task. Finally, statistics are performed to derive the test specifications, resulting in a legally defensible examination blueprint.

When the RDS process has been completed, the agency develops a final Role Delineation Study (RDS) report to document the overall process. The report is written to the standards specified by the *Standards for Accreditation of Certifying Agencies* (National Commission for Certifying Agencies, 2002) and the *Standards for Educational and Psychological Tests* (American Educational Research Associations, American Psychological Association, and National Council on Measurement in Education, 1999), which ensures that all resulting products meet national standards for validity and reliability.

In summary, the goal of an RDS is to identify what the certified person must know and be able to perform to be successful in the role of a peer. This information is referred to as the core competencies of the profession. To identify the core competencies, a group of subject matter experts must be assembled and led through a process to identify job tasks and the knowledge and skills necessary to perform the job tasks. This work must then be reviewed and commented on by persons in the field who are already performing the work. Any differences between the core competencies identified by the subject matter expert group and the field must be resolved before the competencies can be finalized. If the entity intends to identify additional standards that must be met in order to hold the "credential", the standards should tie back to the core competencies in order to ensure that candidates are only being asked to demonstrate the competencies being measured.

In conclusion, the fundamental purposes of a credentialing program include:

- Protecting the public
- Establishing standards for professional knowledge, skills and practice
- Assuring that credentialed professionals have met the standards of practice

In order to achieve these goals, the credentialing organization must ensure that core competencies are identified in a reliable and valid manner. Job Task Analysis and the Role Delineation Study are the two most widely used methods to establish core competencies. All certification program policy decisions must tie directly back to the core competencies, it is critical that the core competencies are correct. For further information on core competencies refer to the following resources:

1. *Standards for Educational and Psychological Testing* (1999, American Psychological Association.)
2. *American Educational Research Association, (*National Council on Measurement in Education.)
3. *Principles of Fairness: An Examining Guide for Credentialing Boards.* (Revised 2002, Council on Licensure, Enforcement, and Regulation, Institute for Credentialing Excellence.)
4. Uniform Guidelines on Employee Selecting Procedures (1978, Equal Employment Opportunity Commission, Civil Service Commission, US Department of Labor, US Department of Justice.)
5. *NCCA Standards for the Accreditation of Certification Programs* (2003, Institute for Credentialing Excellence's National Commission for Certifying Agencies.)

Farrington, A. (2011)

APPENDIX B
SAMPLE JOB DESCRIPTIONS

MENTAL HEALTH ASSOCIATION OF SOUTHEAST PENNSYLVANIA
Job Description
SAMPLE

DEPARTMENT	Service Operations	**LOCATION**	
JOB TITLE	Lead Recovery Coach	**JOB FAMILY**	
REPORTS TO	Program Manager	**DIRECT REPORTS**	
SALARY BAND		**FLSA STATUS**	☐ Exempt ☒ Nonexempt

JOB SUMMARY

The Lead Recovery Coach resolves problems using standard procedures or organizational policies and understands key organizational drivers that influence the execution of initiatives, services, and work processes within a service. The Lead Recovery Coach also provides direction to entry level Recovery Workers/Recovery Coaches and provides technical guidance within a service and/or executes tasks within a service and demonstrates level of knowledge and skills to consistently meet or exceed service requirements.

ESSENTIAL JOB DUTIES

LEADERSHIP

- Provides direction to entry level Recovery Workers/Recovery Coaches and provides technical guidance within a service and/or executes tasks within a service
- Trains others on facilitation of classes that teach the participants the skills available for his/her recovery so that they may internalize a sense of wellness and self-worth
- Trains others in how to handle other aspects of their work.
- Ensures team understands policies and process related to the program.
- Mentors others on use of Electronic records system
- Leads routine meetings to address administrative issues.
- Is a super user on Credible system
- Assists manager conduct presentations to providers about the program.

PEER SUPPORT/COACHING

- Applies general knowledge of Recovery services to complete small projects or conduct a series of tasks with a limited degree of supervision
- Works with participant to identify, develop, and access supports to increase his/her success in community integration and community inclusion
- Supports and teaches recovery principals and recovery tools and models personal responsibility, self-advocacy, and hopefulness
- Facilitates the participant's self-review of progress upon each encounter
- In partnership with each participant assesses their hopes, strengths, accomplishments and challenges in order to achieve his/her stated goals
- In partnership with each participant develops the recovery plan and his/her support system in order to support him/her in becoming self-sufficient
- Supports participants in the self-management of critical or crisis situations.
- Supports participants' in coordinating with or in choosing his/her significant and relevant

supports in order to arrange services or resources to achieve his/her goals.
- Assists the individual in preparation and recording of the peer support recovery plan, encounter notes, and other documents that verify service delivery using person-first language, in a timely manner according to established compliance standards.
- Uses knowledge, skills, training from Certified Peer Specialist training and MHASP's Work Place Capability training to model, coach, support and advocate with participants.

ADMINISTRATIVE

- Enters participant data in the Electronic Healthcare Records system upon intake.
- Ensures that all participants' visits are documented in EHR immediately.
- Ensures that all data is correct by verifying information with the participant on every visit.
- Participates in weekly supervision and in team review of documentation of the comprehensive assessment of participants in various life domains.
- Creates weekly schedule that meets existing program productivity standards and supervision,
- Participates in staff meetings and trainings.

PROGRAM SPECIFIC DUTIES (Depends on the Program)

- May be responsible for handling on-call issues on the weekends and some evening hours.
- May be responsible for working in partnership with the Program Manager in providing support to evening and weekend staff.
- May be responsible for providing input on performance evaluations.

OTHER DUTIES

- Provides technical information to service managers, and executes routine assignments within a service
- Demonstrates level of knowledge and skills within a specific activity to consistently meet or exceed service requirements

ENTRY LEVEL REQUIRMENTS
Education/Certificate/License/Skills and/or Experience

- Bachelor's Degree, preferred or related experience
- Credentialed as a Certified Peer Specialist.
- Minimum of four years of experience in a behavioral health work environment
- Must possess a valid driver's license.
- Demonstrated knowledgeable of the local Mental Health System
- Demonstrated ability to create, read and send e-mail through Google.
- Proficient in Microsoft Word
- Ability to use the Internet to gather information required for the program or program participant
- Must possess basic computer skills to perform job duties including desktop computing, email, time sheet management, electronic health records, using Microsoft Office Applications, ADP and other relevant software
- Must have basic electronic communication and internet skills to gather information required for the program or program participants.
- Must be able to use new computer systems and/or software functions as they become available.

KEY PERFORMANCE INDICATORS
• Demonstrated leadership on Credible system knowledge • Demonstrated leadership as a recovery coach • Demonstrated leadership in ability to advocacy principles • Demonstrated leadership of recovery principles and recovery-oriented treatment programs • Demonstrated consistent behaviors in patience, creativity, flexibility, compassion, and sensitivity to persons with disabilities and other minority populations • Demonstrated ability to adhere to a flex schedule which allows for evening and weekend hours as may be required to respond to individual needs • Completion of 18 hours of continuing education per year, with 12 hours specific to peer support
PHYSICAL DEMANDS
• While performing the duties of this job, the employee is required to sit at a desk with ergonomically appropriate equipment and to do some light lifting up to 25 lbs., climb steps, and walk around multiple MHASP locations and in the community in areas that may not be handicap assessable. Reasonable accommodations will be made to enable individuals with disabilities to perform his/her essential job duties.
EMPLOYEE SIGNATURE
By my signature, I hereby certify that I have reviewed the attached description of my position and agree to perform the duties described therein. I understand that MHASP may make modifications, additions, or deletions to this job description at any time, and will notify me of any changes by sending me a revised copy for my review and signature. Employee Printed Name _____ Date: _____ Employee Signature _____

MENTAL HEALTH ASSOCIATION OF SOUTHEASTERN PENNSYLVANIA
Job Description
SAMPLE

DEPARTMENT		**LOCATION**	
JOB TITLE	Recovery Coach	**JOB FAMILY**	Recovery
REPORTS TO	Service Manager, Supervisor or Director	**DIRECT REPORTS**	None
SALARY BAND	Two	**FLSA STATUS**	☐ Exempt ☒ Nonexempt

JOB SUMMARY

The Recovery Coach provides flexible, community based services that are designed to promote the empowerment, recovery, and community integration of individuals who have severe mental health challenges by facilitating opportunities for individuals receiving service to direct their own recovery and advocacy process, by teaching and supporting the acquisition and utilization of skills needed to facilitate the individual's recovery, promoting the knowledge of available service options and choices and the utilization of natural resources in the community, and helping facilitate the development of a sense of wellness and self-worth.

ESSENTIAL JOB DUTIES

Peer Support/Coaching

- Applies general knowledge of Recovery services to complete small projects or conduct a series of tasks with a limited degree of supervision
- Works with participant to identify, develop, and access supports to increase his/her success in community integration and community inclusion
- Supports and teaches recovery and recovery tools and models personal responsibility, self-advocacy, and hopefulness
- Facilitates the participant's self-review of progress upon each encounter
- In partnership with each participant assesses their hopes, strengths, accomplishments and challenges in order to achieve his/her stated goals
- In partnership with each participant develops the recovery plan and his/her support system in order to support him/her in becoming self-sufficient
- Supports participants in the self-management of critical or crisis situations.
- Supports participants' in coordinating with or in choosing his/her significant and relevant supports in order to arrange services or resources to achieve his/her goals.
- Assists the individual in preparation and recording of the peer support recovery plan, encounter notes, and other documents that verify service delivery using person-first language, in a timely manner according to established quality and regulatory standards.
- Uses knowledge, skills, training from Certified Peer Specialist training and MHASP's Work Place Capability training to model, coach, support and advocate with participants.
- Escorts participants when necessary and ensures participants safety when participating in events, visits, and other interactions.

EHR

- Enters participant data in the Electronic Healthcare Records system upon intake.
- Ensures that all participants' visits are documented in EHR immediately
- Ensures that all data is correct by verifying information with the participant on every visit

Administrative

- Participates in weekly supervision and in team review of documentation of the comprehensive assessment of participants in various life domains
- Creates weekly schedule that meets existing program productivity standards and supervision,
- Participates in staff meetings and trainings.

Other Duties

- Provides technical information to service managers, and executes routine assignments within a service
- Demonstrates level of knowledge and skills within a specific activity to consistently meet or exceed service requirements
- Reports any activities that may violate established laws, regulations, policies or procedures. Raises questions about any actions contrary to law or policy taken by another staff member or employee or yourself, and reports the matter to management or to the Director of QI & C and/ or Human Resources
- Other duties as assigned.

ENTRY LEVEL REQUIRMENTS:
Education/Certificate/License/Skills and/or Experience

- Minimum of a High School or GED Diploma; Associates Degree in a Human Services related field is preferred
- Credentialed as a Certified Peer Specialist.
- Minimum of three years of experience in a behavioral health work environment
- Must possess a valid driver's license.
- Demonstrated knowledge of the local Mental Health System
- Demonstrated ability to create, read and send e-mail through Google.
- Proficient in Microsoft Word
- Must possess basic computer skills to perform job duties including desktop computing, email, time sheet management, electronic health records, using Microsoft Office Applications, ADP and other relevant software
- Must have basic electronic communication and internet skills to gather information required for the program or program participants.
- Must be able to use new computer systems and/or software functions as they become available.

KEY PERFORMANCE INDICATORS

- Demonstrated ability to advocate with participants
- Demonstrated ability to keep boundaries and form appropriate professional relationships with participants.
- Demonstrated knowledge of recovery principles and recovery-oriented treatment programs

- Demonstrated consistent behaviors in patience, creativity, flexibility, compassion, and sensitivity to persons with disabilities and other minority populations
- Demonstrated ability to adhere to a flex schedule which allows for evening and weekend hours as may be required to respond to individual needs
- Completion of 18 hours of continuing education per calendar year, with 12 hours specific to recovery and wellness.

PHYSICAL DEMANDS

- While performing the duties of this job, the employee is required to sit at a desk with ergonomically appropriate equipment and to do some light lifting up to 25 lbs., climb steps, and walk around multiple MHASP locations and in the community in areas that may not be handicap assessable. Reasonable accommodations will be made to enable individuals with disabilities to perform his/her essential job duties.

WORK ENVIRONMENT

- The noise level in the work environment is usually moderate. Reasonable accommodations will be made to enable individuals with disabilities to perform his/her essential job duties.
- Must be willing to work overtime as needed
- Must be able to work holidays

EMPLOYEE SIGNATURE

By my signature, I hereby certify that I have reviewed the attached description of my position and agree to perform the duties described therein. I understand that MHASP may make modifications, additions, or deletions to this job description at any time, and will notify me of any changes by sending me a revised copy for my review and signature.

Employee Printed Name _____ Date: _____

Employee Signature _____

ACMHA Peer Leaders Interest Group (PLIG)

Since 2012, ACMHA's Peer Leaders Interest Group Peer Leader Interest Group has brought together individuals in mental health and/or addiction recovery from across the nation to share common concerns that have included the development of peer services on a national level, integrated peer recovery services, peer leadership training and educational opportunities, wellness and community, peer services research.

PLIG members currently include:

Ben Bass
Brenda Vezina-Jodaitis
Deborah Delman
Chacku Mathai
Carlton Whitmore
Daniel Haley
Donna Conley
Deborah Fickling
Eduardo Vega
Debbie Plotnick
Dona Dmitrovic
Elaine Carroll
Gitane Williams
Jennifer Padron
Janna Spaulding
Joseph Powell
Jack Cameron
Keris Myrick
Patty McCarthy Metcalf
Sheri Jenkins Tucker
Wendy Brennan
Peter Ashenden
Phil Valentine
Joseph Rogers
Nell Hurley
Mary Jo McMillen
Amy Zulich
Walter Ginter
John Rocco
Jim Gillen
Jimi Kelly
Rosie Corliss
John Durbin
Adam Slosberg
Daniel Fisher
Lynda
Jennifer Bliss
Donna Hillman
Tanya Stevens
Andre Johnson
Tom Hill
Harvey Rosenthal
Patrick Hendry