The Provider's Handbook
On Developing & Implementing
Peer Roles

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Peer-to-peer support makes the world go 'round

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Introduction

Welcome to the provider portion of this handbook. Whether this is your first step in considering the implementation of peer roles in your organization, or you're looking for ideas on how to further improve and grow what you've already developed, you will find many great resources herein.

You may be considering peer support because you see the overall benefits, are implementing a directive from the leaders of your organization, or are just responding to new contract regulations. Whatever the reason, there are many things to take into account to ensure success. In the past 15 years, many programs have created, used and researched peer support roles, giving the community a wealth of information about what works and doesn't work to support the integration of this new effort within traditional organizations. This manual strives to:

- Provide you with best practices in peer support;
- Offer tips based on the experiences of other programs that have been studied; and
- Provide a "Nuts and Bolts" toolbox for you and your organization to use.

Note: Language is used very intentionally throughout this handbook (with the exception of quotes from some sources, where word choices are beyond our control). This includes the choice to use 'they' and 'their' rather than 'she or he' or 'his or her.' Although this may produce some angst for the grammarians among us, it is done out of respect for the many people in our community who are questioning or living outside of a gender binary.

Top Ten Misconceptions About Peer Work

We are going to keep coming back to several of these points throughout this book. However, it seems to make sense to put them on the table right from the start. The ten misconceptions listed below are some of the most common misunderstandings about 'peer' roles. We've heard them many times, and don't expect them to go away any time soon. We share them here in hopes you can be a part of the education that will eventually allow us all to leave them in the dust.

1. **Peer workers are just 'mini mental health counselors,' and a next logical step in their career path would be to aim to become a mental health counselor or clinician:** In actuality, working in a peer role is a completely different track than being a mental health counselor. As you will see throughout the pages to come, their focus and duties are substantially different. People working in peer roles also have their own career ladder. There are peer support group facilitators, peer mentors, Certified Peer Specialists, community bridgers, Peer specialist trainers, directors of recovery, and so on.

2. **Peer work is a type of vocational rehabilitation for someone working on their own recovery:** Hiring someone because you like them and think the job will help them in their own recovery is one of the most common (and worst) mistakes an employer can make. Ultimately, this does not serve either the individual or the people receiving services.

3. **Anyone who has received mental health services can make a good peer worker:** A history of receiving mental health services is just a small fraction of what's required to do this job well. The ability and interest in connecting with people, sharing your story, facilitation skills and so much more go into being good at this work. Some people who've received mental health services would make a terrible peer worker, but they'd make a great teacher, scientist, nurse, etc.

4. **One of the primary uses for a peer worker is to get them to uncover information about an individual receiving services to bring back to the rest of the team:** Peer workers should not be used as moles! The trust that a peer worker forms with someone that they are supporting is priceless, and angling to get information just to share it with others can break that trust in a second. If there are particular things that a peer worker would be required to share, they should be as upfront about that as possible. Otherwise, they should be given flexibility in what they do and don't bring back to the team.

5. **Peer workers should never engage in conversation about tricky topics like suicide, medication, etc:** Peer-to-peer conversations shouldn't be limited to light or social topics. Actually, there are a growing number of trainings available to support peer workers to talk about issues like suicide. Sometimes, a peer worker might be the only person that someone feels comfortable sharing these thoughts and feelings with, and so they should be supported to develop their skill level and confidence in having serious conversations as they arise.

6. **There are no boundaries in peer work:** It's true that people in peer roles set limits that are different than people working in clinical roles. However, that doesn't mean it's a free-for-all. Anyone who's been through a Certified Peer Specialist training is subject to a Code of Ethics that includes limitations and boundary considerations. Many other trainings also address similar concerns.

7. **The primary difference between a peer worker and a provider is that the peer worker has 'lived experience' and can share their story:** Lots of people working in provider roles identify as having 'lived experience,' and some organizations even support people in regular provider roles to share their stories. Although sharing one's story is a core part of being a peer worker, there are many other elements that differentiate these roles.

8. **Anti-psychiatry is really common in the peer movement, and many peer workers are likely to tell individuals who receive services to get off their meds or go against what their treatment providers want them to do:** People working in peer roles have a variety of beliefs and experiences—often a mix of good and bad, where the mental health system is concerned. However, most importantly, whether a peer worker has had a good experience with the mental health system or not, all of their training is to not push someone receiving services in any direction (either to comply with or reject treatment recommendations, etc.). Instead, the peer role is focused on supporting the process of self-determination and exploration as determined by the person receiving services.

9. **An organization needs to develop special policies for peer workers and learn how to evaluate who is and isn't stable enough during the interview process:** The reality is that all employees have the potential to be good or bad at their jobs, or have personal issues that arise and impact their work. Anyone who has served as a manager in any field will know that. People working in peer roles should not be treated any differently. While an organization may benefit from re-evaluating its polices to make sure they represent at least some degree of flexibility, fairness and compassion toward their workforce, the policies should be applied across the board.

10. **As long as we're all invested in integrating peer roles, and take all the rights steps, this should be easy, right?:** Any change is going to bring about tension, and especially one that asks an organization to shift elements of its belief system. In actuality, complete lack of tension or bumps in this process should be a red flag that you may not be implementing the roles properly!

Adapted from the Western Massachusetts Peer Network's 'Myths & Misconceptions: Shedding the Misunderstandings as a First Step to Progress' (2011)

Peer Support: A Brief History

To understand "peer support," it's important to look at the meaning of the word "peer." "Peer" is a *relational* term that indicates a connection or relationship amongst *two* or more people based on similar attributes, characteristics or experiences. (**Note:** there is no reference to "the peers" or "a peer" in this book—with the exception of a few quotes from outside sources– because the term really should not be boiled down to a single person, as if it were their identity.) We often speak of "peer pressure" to describe experiences within groups of young adults, or "peer reviewed" when professional articles are read and approved by others in our same professional area. "Peerness" links people through commonalities and similar experiences.

"Peer support," then, is when people who share these comparable experiences offer each other encouragement, empathy, hope, consideration, respect and empowerment from the vantage point of experiential understanding. The "been there, done that..." connection creates a unique understanding and eliminates the power and authority typically associated with helper roles.

It is also worth noting here that sometimes systems have a tendency to get too literal *and* too lax about what constitutes a commonality relevant enough to consider two or more people "peers." It is equal parts mistake to assume that people need to, for example, have the same diagnosis or same type of distress to offer one another peer-to-peer support, as it is a mistake to assume that all people who have been diagnosed or received mental health services will be a fit for one another. Sometimes, simply being human with one another is enough. Other times, the commonality may be more specific like both having heard voices, both having been dependent on Social Security Disability Income, both having experienced involuntary hospitalization, and so on.

Peer support is not a new phenomenon - it has probably existed in some way since the dawn of human beings. It is a natural tendency for us to seek out those who have walked similar paths and can truly understand us.

Some of the earliest signs of organization of peer support efforts was among Native American struggling with substance abuse in the 1770s. However, formalized peer support really took hold with the founding of Alcoholics Anonymous in 1935. Each person, from the one who is just 24 hours sober to someone who is clean for 24 years, is seen as bringing value to the conversation, and it is fully peer-run. There are no professionals acting within their professional roles within the halls of 12-step meetings. It is this level of mutuality and sharing of experiential knowledge that is one of the hallmarks of peer support.

Within the mental health recovery framework, peer support grew out of a human rights movement, as well. In the 1970's, people who saw themselves as having survived the hospital experience were connecting with each other, offering support and validation that they were recovering (despite what they had been told was possible or not), and uniting in the righteous indignation at the abuses they had endured as part of what they were told was their treatment. People bonded together to not only provide mutual support, but to change the way things were done so that others wouldn't have to endure the same abuses they had experienced. Unlike other areas of peer support, mental health has always included a segment of people who have taken on the mission of speaking out about conditions within mental health services and exposing it to the public to advocate for change. This dates back to the 1800's with the written works of such people as Katherine Packard, John Thomas Percival and Clifford Beers, the founder of Mental Health America.

Out of the rallying call against how things were came the mission of having an active role in facilitating the change process. "Nothing About Us Without Us" became a familiar mantra (borrowed from the disability rights community at large), and writings like "On Our Own" by Judi Chamberlin were published to offer guidance for peer-run supports as a more humane alternative to traditional systems of care.

Peer supports took their place as stand-alone, peer-run organizations separated from mainstream services. Some people were paid and others were volunteers, but either way, supports were provided by individuals who were themselves in recovery. Some organizations functioned as drop-in centers; others had a more educational approach, while others played more of an advocacy/activism role.

Over time, partnerships between public behavioral health professionals and people with personal experience developed, and more representatives were invited to participate in planning, developing, delivering and evaluating mental health services. Pioneering agencies created roles for people in recovery, and state agencies began to create liaison roles, often called the "Office for Consumer Affairs." For the most part, however, peer supports were in the community, trying to influence change from the outside, strategizing for ways to be invited to the tables, and trying to get the message of recovery to people in any way possible. Peer support was offered within these community settings in a variety of ways, from 1:1 support and encouragement, educational classes like Wellness Recovery Action Planning (WRAP), empowerment and leadership forums, etc.

While many agencies were developing a desire to incorporate more peer roles, the lack of funding streams was a primary barrier. In 1999, Georgia was successful in getting approval for a dedicated "Certified Peer Specialist" role in their state Medicaid. This became the catalyst needed for a ground swell of change in peer supports within traditional mental health systems. What started out as peer support groups and "consumer-run" organizations has now evolved to include formal peer support

via behavioral health agencies, complete with a training curriculum to ensure that people working in peer roles meet predetermined competency criteria before engaging in support roles. Both informal and formal organizations have valuable roles in the overall system and enhance the spectrum of recovery support options.

It's also worth noting that—concurrent to the development of peer roles– many organizations have also re-visited the idea of supporting all of their employees to have more latitude to self-disclose about personal experiences. Although, disclosing as a clinician does not make the relationship peer-to-peer, many are now finding value in sharing experiences across many borders that were previously considered uncrossable.

One group that has done some intentional work on the exploration of self-disclosure in clinical environments is the Transformation Committee in Massachusetts. In 2007, they produced a document called, "Promoting a Culture of Respect: Transcom's Position Statement on Employee Self Disclosure in Mental Health Service Workplaces."

For those interested in reviewing the statement, it can be found here: http://m-powerblog.org/CultureofRespect-DisclosureEndorsed2-23-07-1.pdf

SIDE BAR: The Pros and Cons of Medicaid Funding for Peer Supports

The most obvious 'pro' for seeking Medicaid reimbursement of peer supports is that it offers another funding source. That, of course, means the likelihood of new jobs and more opportunities all around. It may even open the door for individuals to create 'private practices' of peer support, and could help out some small organizations currently caught in the merry-go-round of endless grant proposals to sustain their work.

However, there is worry that Medicaid funding of peer roles may substantially alter the nature of peer-to-peer support. For example, peer-to-peer support is not intended to be medicalized in nature. In fact, people in peer roles should be trained to be open to a variety of perspectives (trauma, etc.) and ways of understanding distress. Unfortunately, by the very nature of how Medicaid works, it requires proof of medical necessity of any support or services offered which would likely push a medical perspective on peer-to-peer connections. People in peer roles in states where Medicaid billing is already approved are also known for using much more medical and clinical language which can also be harmful to the peer-to-peer relationship.

A medical perspective is not the only issue. For example, note taking about people is generally discouraged in peer-to-peer relationships. Whereas, documentation is required for Medicaid billing. Peer-to-peer relationships also tend to emphasize flexibility and where a person is at that day, rather than more rigid, goal-specific interventions often required through insurance systems.

Medicaid also tends to add hoops for even accessing supports. For instance, in one state where certain peer supports are approved for Medicaid billing, individuals need to get approval from their Case Managers before joining Wellness Recovery Action Planning (WRAP) groups. This is a direct result of Medicaid billing requirements.

Some groups are working on creative ways of looking at the Medicaid billing process to see if the funds might be accessed without impacting the integrity of the role, but the jury remains out!
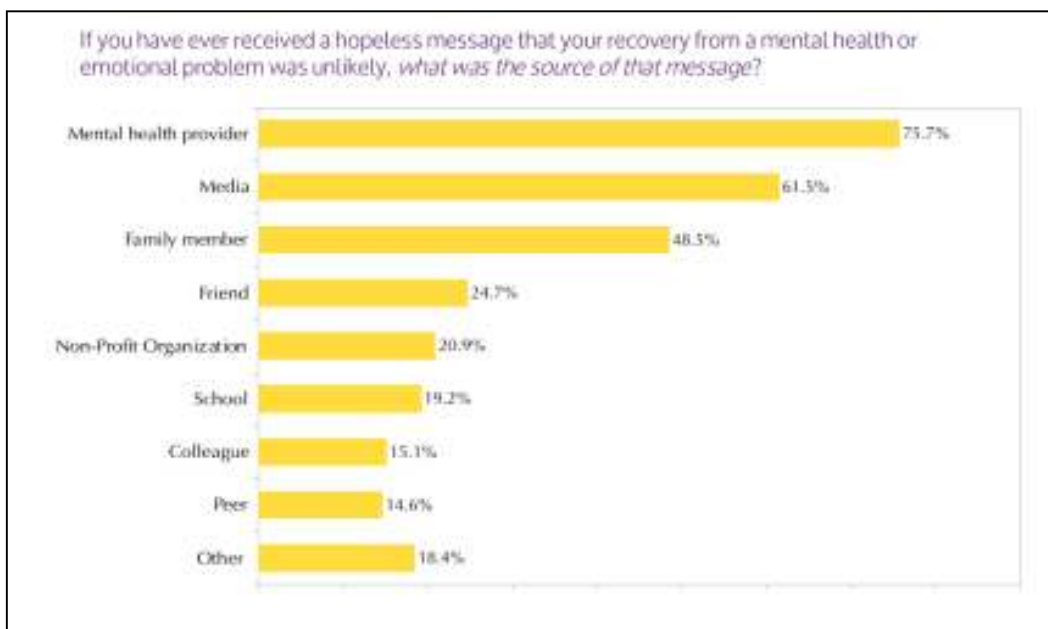
Common Goals Vs. Tensions

As noted in the introduction, organizations consider implementing peer support roles at different times and for varied reasons. Sometimes, when an organization is asked to implement these roles as a requirement from a funding source, they are tasked with doing so on a timeline that simply does not allow for them to understand what peer support even looks like.

Lack of understanding has the potential to bring many bumps in the road, and get everyone off on the wrong foot. One (of many) common misunderstanding about peer roles is the idea that people will enter the organization with a completely different set of goals for the people receiving services there. In fact, in the basic sense, most people in peer and clinical roles often share a number of priorities, including:

- Supporting people to experience less distress
- Supporting people to find satisfaction and contentment in their life
- Supporting people to have hope for moving forward

In 2012, Mindfreedom, International's 'I Got Better' campaign distributed a survey to which 390 people who had used services responded. As you can see from the table below, a substantial majority of people felt they had received messages of hopelessness directly from the mental health provider system. Whatever our differences, it would seem we can all agree that we want to work *together* to do what we can to reduce the numbers of people who have that experience moving forward. Fortunately, as you'll see throughout this handbook, adding a peer support component is a great way to move toward that goal. ('Peer support' was most commonly named as the source of the most hope in the same survey.)

If you have ever received a hopeless message that your recovery from a mental health or emotional problem was unlikely, *what was the source of that message?*

Source	Percentage
Mental health provider	75.7%
Media	61.5%
Family member	48.5%
Friend	24.7%
Non-Profit Organization	20.9%
School	19.2%
Colleague	15.1%
Peer	14.6%
Other	18.4%

Another common misconception about peer roles is that it is 'all about peer support.' In truth, while some common goals are shared, people working in peer roles do often come with different tools and perspectives about how to 'get there.' This is typically by virtue of both their personal experience *and* their training. (Any good training on peer-to-peer support is also going to talk about advocacy skills!) Thus, people working in these roles not only need to function as peer-to-peer supporters, but also as change agents.

So, while your new employees may not enter with a completely different agenda, they will inevitably be suggesting some changes and shifts in both perspective and approach. Even if this is done with the utmost skill, you should anticipate some tension. However, given that tension is a temporary but unavoidable sign of change, it should be welcomed. In fact, lack of any tension with the implementation of a brand new peer role should be regarded as a red flag.
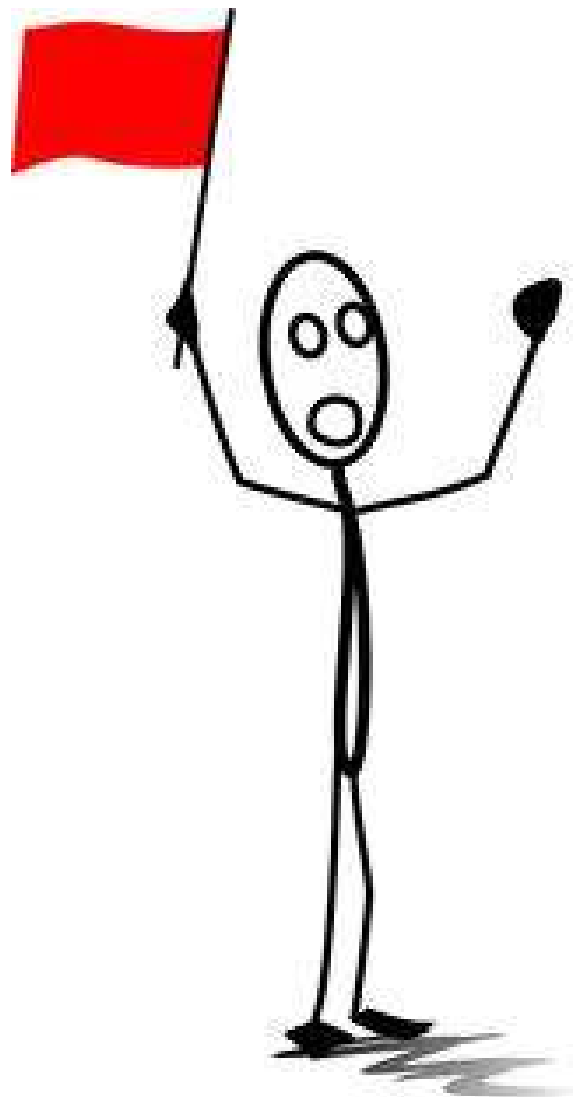
Understanding the Basics: Peer Support Values

While people working in both 'peer' and non-peer roles want to see similar outcomes, such as a person feeling better or reaching his/her goals, people in peer roles have a different set of values as the basis for their work. The values below are derived from research done in the **United States (Judith Campbell), Canada (Mary O'Hagan), Scotland (Simon Bradstreet), Australia and New Zealand.**

Mutuality & Equality -

Minimization of power plays a central role in peer practice. Peer practice values mutuality and equality in healing relationships. Rather than power-over, mutual peer support shares power, is empowering, and transparent on both sides.   Known as the "Peer Principle," the "relationship between the peer worker and the peer they are working alongside is one founded on learning together rather than one person in the helper role and the other on the receiving end. The relationship is central and is grounded in the sharing of experiences with empathy and mutuality thus encouraging relationships that are equal, accepting and respectful." (Bradshaw)

Mutuality in the formalized peer-to-peer relationship is described by leading educator, Shery Mead, as:

- Both people sharing.
- Learning from each other.
- Both figure out the rules of the relationship.
- Power structures are always on the table and negotiated.

Peer support is "..a system of giving and receiving help founded on the key principles of respect, shared responsibility, and a mutual agreement of what is helpful." (Mead et al, 2001)

One of the most common misunderstandings of 'mutuality,' is the idea that, if there is mutuality in a relationship, the person working in the peer role may one day show up and unload all of their personal issues on the person their employer is expecting them to support. On the contrary, people working in these roles are still intended to hold the mission and tasks of their position. However, doing so with 'mutuality' means that the focus is on the relationship (rather than either individual), and how each person can still learn from and be impacted by that connection, regardless of the other responsibilities they are holding.

Self-determination & Empowerment -

A core value in peer support is self-determination. Participation is entirely voluntary and it is up to each person to decide what is best for him or herself. It is the responsibility of the organization to

to give people the choice of whether and how they use peer supports offered. Peer support workers should not have people assigned to them or carry a "case load."

Power as a commodity is something that is rarely given away and most generally has to be taken in some form. An important aspect of the role of the peer worker is to create an environment which is conducive to people taking a greater degree of power and control in their own recovery. Empowerment is about gaining confidence in one's own capacity to make decisions and have control over one's life. It is fundamental to personal recovery.

"It is the role of the peer worker to ensure that service users are empowered to take control of their own recovery, and encouraging an environment where both parties can share their experiences of what works." - Campbell and Lever, 2003

In considering the value of self-determination and how best to preserve it, it is also important to consider how the organization will protect against someone working in a peer role being drawn into situations where there's even the appearance of force, coercion or lack of priority on the individual's self-determination.

Empathy -

Empathy can be understood as the ability to relate with another person through understanding their experience from their point of view, often referred to as worldview. This is sometimes described as 'being in someone else's shoes.' As people working in peer roles necessarily have personal experience with psychiatric diagnosis, receiving services, emotional/mental distress, and/or trauma, they are in a unique position to offer support to others in order to improve the quality of their lives. People who work in these roles are considered to be able to closer relate in an empathic way through the power of having been there:

"We've 'been there, done that, got the T shirt' which, to most of us, explains it all." - Highland Users Group, 2008
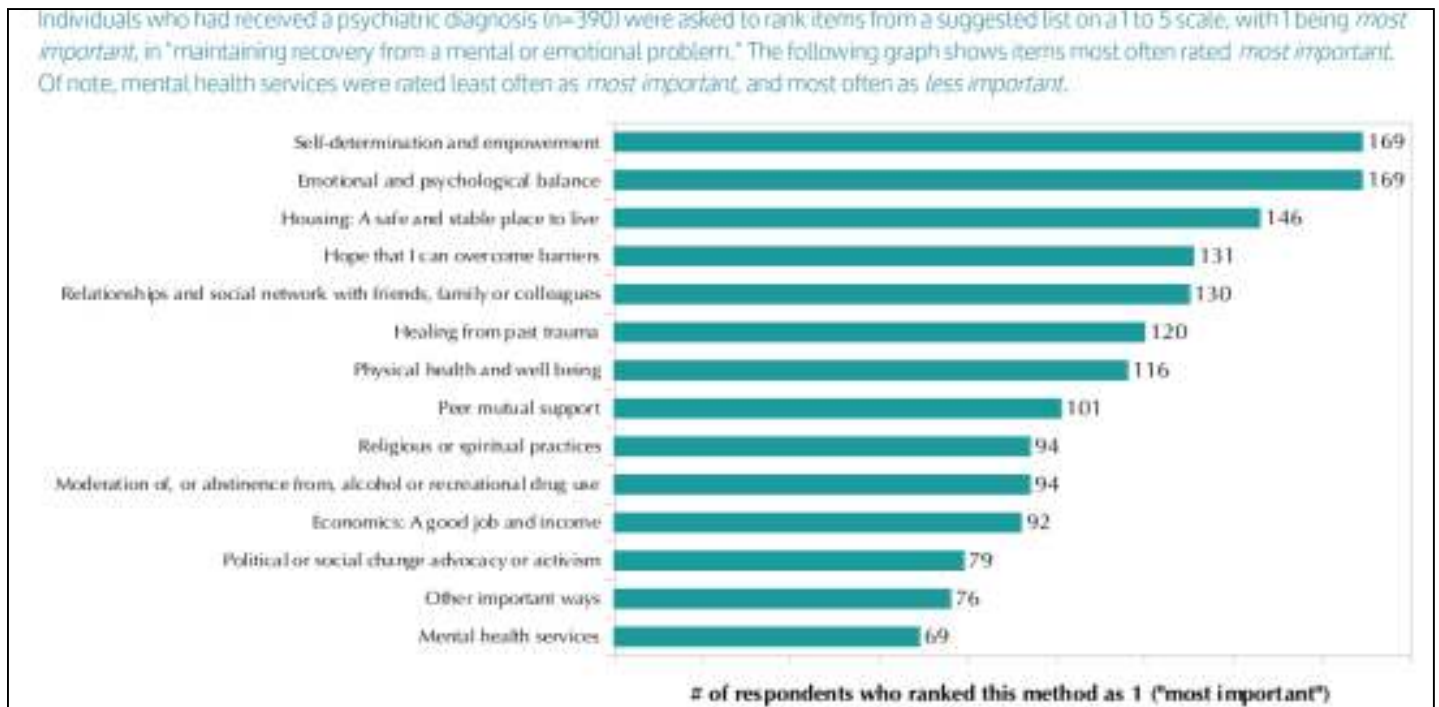
Recovery -

Peer support initiatives strive to be holistic and to encompass the psychological, social and spiritual domains of life. They aim to offer hope and tools for recovery and personal growth. Peer support

helps people gain a sense of purpose and personal responsibility. It encourages people to reframe their stories to move beyond an illness or victim identity. Its goal is to enable them to be "the architects of their own wellbeing." (Making the Case for Peer Support: Report to the Mental Health Commission of Canada, Mary O'Hagan et al, 2010.)

In a survey of people using services, the dominance of the deficits approach and medical model in mental health services was criticized as either limited or harmful. Peer support was found to support people to regain a healthy identity, as well as roles and relationships that had been disrupted by their distress and/or use of services. Recovery and hope is reflected in the following types of attitudes and behavior:

- when people believe in each other;
- when they feel better about themselves;
- when they feel optimistic about their future; and
- when they are making positive changes in their lives.

Going back to the same Mindfreedom survey referenced earlier in this handbook, these values resonate throughout the results when respondents were asked to rank what contributed most strongly to their healing process.

Individuals who had received a psychiatric diagnosis (n=390) were asked to rank items from a suggested list on a 1 to 5 scale, with 1 being *most important*, in "maintaining recovery from a mental or emotional problem." The following graph shows items most often rated *most important*. Of note, mental health services were rated least often as *most important*, and most often as *less important*.

Item	# of respondents
Self-determination and empowerment	169
Emotional and psychological balance	169
Housing: A safe and stable place to live	146
Hope that I can overcome barriers	131
Relationships and social network with friends, family or colleagues	130
Healing from past trauma	120
Physical health and well being	116
Peer mutual support	101
Religious or spiritual practices	94
Moderation of, or abstinence from, alcohol or recreational drug use	94
Economics: A good job and income	92
Political or social change advocacy or activism	79
Other important ways	76
Mental health services	69

# of respondents who ranked this method as 1 ("most important")

Check out the 'Declaration on Peer Roles' in the peer support section of this handbook for more on values!

Peer Support: The Evidence Base

Sometimes providers have not had the opportunity to review the research in support of peer roles, or aren't aware that such research exists. Becoming more familiar with the many careful studies demonstrating the value of peer roles can aid in confidence building and overall understanding across an organization. This section offers both findings and a list of references that you can seek out and review yourself (or share with others in your organization!). For your convenience and possible interest, references include both those pertaining to peer support in provider environments and those pertaining to offerings run directly by peer-to-peer organizations.

Peer support workers bring valuable skills to the organizations in which they work. "In programs which hire [peer workers], numerous, desirable attributes and abilities of [peer] employees have been noted … system knowledge, 'street smarts', responsiveness, coping strategies, patience & flexibility, relational emphasis, issues identification, engagement abilities, role modeling, advocacy against stigmatization, and educational activity with co-workers." (Van Tosh, 1993, Dixon et al, 1994).

While the numbers of people in peer support roles is growing, the academic literature is only now beginning to catch up. A growing body of literature has increasingly been able to demonstrate positive outcomes for peer support in the context of self help groups, peer-run organizations, as well as peer support workers in mainstream services. Several projects conducted over the past decade have been earning peer support-based organizations recognition as evidence based practices (Centre for Research and Education in Human Services, 2004).

Much of the research that was first conducted on peer support in mainstream mental health organizations focused on whether there was any risk to those receiving services. The first stage of research involved feasibility studies, in which the main aim was to demonstrate that it was in fact possible to train and hire people with histories of receiving mental health services to work in peer support roles. Given the history of discrimination and prejudice against people with psychiatric diagnoses, many felt it was necessary to first show that people with such backgrounds could perform the tasks involved. (Davidson, 2012).

While often this research focused on people with personal experience working in traditional service roles (e.g., case managers), the evidence base developed to show that no detrimental effect was shown and that outcomes were equivalent for people receiving services from both people with and without psychiatric histories (Chinman et al., 2006; Davidson et al., 2006; Simpson & House, 2002). Four randomized controlled trials conducted during the 1990s demonstrated consistently that people

were able to function adequately in these roles and to produce outcomes at least on a par with those produced by people who did not openly identify as having their own experience in the system (Clarke, et al, 2002, Davidson, et al., 2004, O'Donnell, et al., 1999, Solomon and Draine, 1995), with the studies by Clarke and O'Donnell showing slightly better outcomes for those receiving support from people who had personal lived experience in addition to usual care as compared to those receiving usual care only.

Similar to the first stage, the second stage of research involved studies comparing employees who had openly identified psychiatric histories vs. those who did not, with both functioning in conventional roles such as case managers, rehabilitation staff, and outreach workers. The main difference in this stage is that it was more or less accepted by researchers that hiring people with psychiatric histories was not doing harm, but they still wanted to take a closer look at benefits. In these studies of conventional services, most studies again found that people with personal histories of receiving services functioned at least as well in these roles as other staff did, with comparable outcomes (Felton, et al., 1995, Chinman, et al., 2000, Landers & Zhou, 2011, Sells, et al., 2006).

A third stage of research is now emerging that focuses more specifically on the differences between peer and non-peer supports in relation to system outcomes and personally defined benefits by people receiving peer supports. One group of research has focused on utilization of supports, finding:

- Reduced rates of hospitalization and days spent as inpatient (Solomon and Drain, 1995; Rowe, et al, 2007; Sledge, et al., 2011)
- Decrease in use of emergency rooms (Davidson et al., 2012)
- Decrease in need of mental health services over time (Chinman et al., 2011, Simpson & House, 2002)

Other research has focused on how peer support interventions have impacted people's experience of distress:

- Decreased substance use among persons with co-occurring substance abuse issues (Rowe, et al., 2007, Sledge, et al., 2011)
- Decreased participants' level of distressing symptoms (Tondora, et al., 2010)
- Decreased experience of depression (Sledge, et al, 2011)
- Reduced overall symptoms (Campbell, J. et al, 2004);

Finally, research has focused on the people's subjective experiences from experiencing peer support:

- Increased the degree to which participants felt their care was responsive and inclusive of non-treatment issues (such as housing and employment) (Davidson, et al., 2012)
- Increased sense of control and ability to bring about changes in their lives. (Tondora, et al., 2010)
- Increased sense of hope and degree of engagement in managing their challenges, degree of satisfaction with family life, positive feelings about themselves and their lives, social support, and sense of community belonging. (Tondora, et al., 2010)
- Increased hope, self-care and sense of well-being (Sledge, et al. 2011)
- Enlarged social networks and enhanced quality of life, especially when peer supports are offered with traditional mental health services, according to a multiyear study by the Center for Mental Health Services (Campbell, J. et al, 2004);
- Enhanced quality of life when peer workers are integrated into an intensive case management program (Felton et al, 1995); and
- Peer supports generating superior outcomes in terms of engagement of "difficult-to-reach" people (Davidson, et al., 2000)

Due to the above and other research being generated throughout the world, peer supports today are recognized as legitimate, evidenced-based offerings.

Anyone who has had a personal problem and sought out guidance from another who has faced a similar situation understands the power of peer support. There often is an instant connection, and, if the other person has come through the problem, a sense of hope that recovery is possible.

*'The essence of peer support begins with informal and naturally occurring support, which is also normally the bedrock of service user groups. In essence, service users use their own knowledge and expertise to help both themselves and others. This help has the authenticity of being rooted in personal experience, which is acknowledged as the most powerful and effective way of learning. **As peer support becomes more structured and organized, it can become more focused and helpful but care must be taken that its essence is not lost within these more formal and professional structures.'** (Faulkner and Basset, 2010)*

The peer role carries the history of its roots, and remains a "change agent" role, in addition to providing peer support to people using services. Peer workers are trained to identify agency policies and procedures that may have unintended negative impacts on people being supported by an agency, such as identifying stigmatizing and discriminating practices or language in published documents, including the agency's mission, vision and values statements. Peer supporters heighten sensitivities to such negative practices and language, and are a resource for reinforcing responsive and respectful messages.

> *"What I like about the peer workers is that they have the ability to listen to something and hear it totally differently than regular staff because they have been there. ...They understand what a person is going through, and they have a lot of good insight into some solutions." - An administrator, Peer Support 101, Alaska Peer Support Consortium*

The presence of peer workers also helps to decrease stigma or discrimination that may exist amongst colleagues. As peer workers become involved with all aspects of the organization (i.e., boards, committees, staff, program planning, etc.), other staff gain more exposure and experience with people in recovery, helping to overcome old myths about chronicity embedded in the medical model and conventional system approaches.

The presence of a peer roles within mainstream mental health services is a key component towards agencies reaching their stated goals of truly becoming "recovery oriented" services.

References*

Bergeson, S. (n.d.) Cost effectiveness of using peer providers. Retrieved from: http://bit.ly/1lbypF7

Bologna, M.J., Pulice, R.T., (2011). Evaluation of a Peer-Run Hospital Diversion Program: A Descriptive Study. *American Journal of Psychiatric Rehabilitation*, 14 (4): 272-286.

Bouchard, L., Montreuil, M., Gros, C. (2010). Peer support among inpatients in an adult mental health setting. *Issues in Mental Health Nursing.* 31:589-598. DOI: 10.3109/01612841003793049

Bradstreet, S. (2006*) Harnessing the 'lived experience'. Formalising peer support approaches to promote recovery.*The Mental Health Review.Vol 11, 2, 33-37.

Campbell, J., Lichtenstein, C., Teague, G., Banks, S., Sonnefeld J., Johnsen, M., Zempolich, K., & COSP Steering

Committee. (2004). *Consumer-operated services program (COSP) multi-site research initiative: Overview and preliminary findings.* Presentation to Alternatives Conference, October 16, 2004.

Chamberlin, J. (1988) *On Our Own: patient-controlled alternatives to the mental health system*. London: Mind Publications.

Chinman M, Rosenheck R, Lam J. (2000) *Comparing consumer and non-consumer provided case management services for homeless persons with serious mental illness.* J NervMent Dis.188:446–453.

Chinman, M. J., Weingarten, R., Stayner, D., Davidson, L. (2001) *Chronicity Reconsidered. Improving Person-Environment Fit Through a Consumer-Run Service.* Community Mental Health Journal.Vol 37, 3, 215-229.

Chinman M, Young AS, Hassell J. (2006) *Toward the implementation of mental health consumer provider services.* J Behav Health Serv Res. 2006;33:176–195

Clarke GN, Herincks HA, Kinney RF. (2000) *Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: findings from a randomized trial of two ACT programs vs. usual care.* Ment Health Serv Res. 2:155–164.

Cook, J.A., Copeland, M.E., Corey, L., Buffington, E., Jonikas, J.A., Curtis, L.C., Grey, D.D., & Nichols, W.H. (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):113-120.

Corrigan, P. (2006). Impact of consumer operated services on empowerment & recovery of people with psychiatric disabilities. *Psychiatric Services* 57(10): 1493-1496.

Daniels, A., Grant, E., Filson, B., Powell, I., Fricks, L., Goodale, L., (eds), (2010) *Pillars of Peer Support: Transforming Mental Health Systems of Care, Through Peer Support Services,* www.pillarsofpeersupport.org; January, 2010.

Davidson, L, Belamy, C., Guy, K and Miller, R. (2012) *Peer support among persons with severe mental illnesses: a review of evidence and experience.*World Psychiatry. Jun 2012; 11 (2): 123–128.

Davidson L, Chinman M, Sells D. (2006) *Peer support among adults with serious mental illness: a report from the field.* Schizophr Bull. 32:443–450.

Davidson L, Shahar G, Stayner DA. (2004) *Supported socialization for people with psychiatric disabilities: lessons from a randomized controlled trial.* J Commun Psychol. 32:453–477.

Davidson L. *Living outside mental illness: qualitative studies of recovery in schizophrenia.* New York: New York University Press; 2003.

Davidson L, Stayner DA, Chinman MJ. (2000) *Preventing relapse and readmission in psychosis: using patients' subjective experience in designing clinical interventions.* In: Martindale B, editor. Outcome studies in psychological treatments of psychotic conditions. London: Gaskell; pp. 134–156.

Department of Health (2010b) *Putting People First: Planning Together – peer support and self-directed support.* London: Department of Health.

Dixon, L., Krauss, N. & Lehman, A. (1994).*Consumers as service providers: The promise and challenge*. Community Mental Health Journal, 30(6), 615-634.

Faulkner, A. & Basset, T (2010) *A Helping Hand: Consultations with Service Users about Peer Support.* London: Together/University of Nottingham/NSUN.

Felton CJ, Stastny P, Shern D. (1995) *Consumers as peer specialists on intensive case management teams: impact on client outcomes.* Psychiatr Serv. 46:1037–1044.

Gillard, S.G., Edwards, C., Gibson, S.L., Owen, K, & Wright, C. (2013). Introducing peer worker roles in UK mental health service teams: A qualitative analysis of the organizational benefits and challenges. BMC Health Services Research, 13 (188). DOI: http://www.biomedcentral.com/1472-6963/13/188

Greenfield, T.K., Stoneking, B.C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of mental health consumer-managed alternatives to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology,* 41(1):135-144.

Landers GM, Zhou M. (2011) *An analysis of relationships among peer support, psychiatric hospitalization, and crisis stabilization.* CommunMent Health. 47:106–112.

Lawn, S, Smith, A., & Hunger, K. (2008). Mental health peer support for hospital avoidance and early discharge; an Australian example of consumer driven and operated service. J Ment Health 2008, 17(5):493-508.

McDiarmid, D., Rapp, C., & Ratzlaff, S. (2005). Design and initial results from a supported education initiative: The Kansas consumer as provider program. Psychiatric *Rehabilitation Journal*, 29(1):3-9.

McLean, J., Biggs, H., Whitehead, I., Pratt, R., Maxwell, M. (2009) *Evaluation of the Delivering for Mental Health Peer Support Worker Pilot Scheme.*

Mead S, Hilton D, Curtis L. (2001) *Peer support: a theoretical perspective*. PsychiatrRehabil J. 25:134–141

Migdole, S., Tondora, J., Silvia, M.A., Barry, A.D., Milligan, J., Mattison, E, Rutledge, W, & Powsner, S. (2011). Exploring new frontiers: Recovery-oriented peer support programming in a psychiatric ED. *American Journal of Psychiatric Rehabilitation*, 14(1): 1-12.

Nelson, G, Ochocka, J., Janzen, R., Trainer, J., Goering, P., & Lomotey, J. (2007). A longitudinal study of mental health consumer/surivovr Initiatives: Part V—Outcomes a 3-year follow-up. *Journal of Community Psychology,* 35(5):655-665

O'Donnell M, Parker G, Proberts M. (1999) *A study of client-focused case management and consumer advocacy: the Community and Consumer Service Project*. Aust N Z J Psychiatry. 33:684–693.

Ostrow, L, & Leaf, P. (2014). Improving capacity to monitor and support sustainability of mental health peer-run organizations. *Psychiatric Services,* 65(2):239-241.

Peer Support 101, Alaska Peer Support Consortium (2011).

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S.E., Ryan, R., & Berends, L. (2013). Consumer providers of care for adult clients of statutory mental health services (review). John Wiley & Sons, Ltd. DOI: 10.1002/14651858.CD004807.pub2

Repper, J., & Carter, T. (2011) A review of the literature on peer support in mental health services. *J Ment Health,* 20(4):392-411.

Repper, J. & Carter, T. (2010) *Using Personal Experience to Support Others with Similar Difficulties: A Review of the Literature on Peer Support in Mental Health Services*. London: Together/University of Nottingham/NSUN.

Repper, J. & Perkins, R. (2003) *Social Inclusion and Recovery*: A Model for Mental Health Practice. London: BalliereTindall.

Resnick, S. & Rosenheck, R.A. (2008). Integrating peer provided services: A quasi experimental study of recovery orientation, confidence, and empowerment. *Psychiatric Services,* 59(11): 1307-1314.

Rogers, E.S., Teague, G.B., Lichenstein, C., Campbell, J., Lyas, A., Chen, R., & Banks, S. (2007). Effects of participation in consumer-operated service programs on both personal and organizationally mediated empowerment: Results of multisite study. *Journal of Rehabilitation Research & Development,* 44(6): 785-800.

Rowe M, Bellamy C, Baranoski M. (2007)*Reducing alcohol use, drug use, and criminality among persons with severe mental illness: outcomes of a Group- and Peer-Based Intervention*. Psychiatr Serv. 58:955–961.

Sells D, Davidson L, Jewell C. (2006) *The treatment relationship in peer-based and regular case management services for clients with severe mental illness*. Psychiatr Serv.57:1179–1184.

Shatell, M.M., et al. (2014). A recovery-oriented alternative to hospital emergency departments for persons in emotional distress: "The living room." *Issues Ment Health Nurs.,* 35(1): 4-12.

Simpson, A, et al. (2014). Results of a pilot randomized controlled trial to measure the clinical and cost effectiveness of peer support in increasing hope and quality of life in mental health patients discharged from hospital in the UK. BMC Psychiatry, 14(3). Doi:10.1186/1471-244X-14-303.

Simpson EL, House AO. (2002) *Involving service users in the delivery and evaluation of mental health services: systematic review.* BMJ. 325:1265–1270

Sledge WH, Lawless M, Sells D. (2011) *Effectiveness of peer support in reducing readmissions among people with multiple psychiatric hospitalizations*. Psychiatr Serv. 62:541–544.

Solomon P, Draine J. (1995) *The efficacy of a consumer case management team: two-year outcomes of a randomized trial.* J Ment Health Adm. 22:135–146.

Solomon P, Draine J, Delaney M. (1995) *The working alliance and consumer case management*. J Ment Health Admin. 22:126–134.

Spirito Dalgin, R., Maline, S., & Driscoll, P. (2011). Sustaining recovery through the night: Impact of a peer-run warm line. *Psychiatric Rehabilitation Journal.* 35(1):65-68.

Tondora J, O'Connell M, Dinzeo T.(2010) *A clinical trial of peer-based culturally responsive person-centered care for psychosis for African Americans and Latinos*. Clinical Trials. 7:368–379

Van Tosh, L. (1993)*Working for a change: Employment of consumers/survivors in the design and provision of services for persons who are homeless and mentally disabled.* Rockville, MD, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Walker, G., & Bryant, W. (2013). Peer support in adult mental health services: A metasynthesis of qualitative findings. *Psychiatric Rehabilitation Journal,* 36(1): 28-34.

Wexler B, Davidson L, Styron T. (2008) *Severe and persistent mental illness.* In: Jacobs S, Griffith EEH, eds. 40 years of academic public psychiatry. London: Wiley;pp. 1–20.

* The references above reflect not only materials used for the writing of this section, but also other materials that you might find useful in your own readings.

Early Implementation: Building the Foundation

A successful launch of peer support roles depends almost exclusively on provider agencies following a prescribed set of processes.

Buy-in from executive level and Board of Directors

> ***"One key finding (from the Evaluation of the Mental Health Peer Support Worker Pilot) was that peer support works best when peer workers are based in settings that have a pre-existing commitment to the values and principles of recovery. Peer workers greatly enhance that commitment to recovery; however the role should not be used to introduce recovery to settings that do not already have a commitment to the values of recovery." -*** *Experts by Experience, p. 14*

Experience shows that having strategic support for the development of peer roles is vital. Having senior management who champion the role shows leadership and organizational commitment. Successful implementation is enhanced where teams and organizations are well informed about the peer worker role, and supportive of its development at all levels.

Getting buy-in from the board of directors, the executive director and the management staff are critical components. "Buy-in" means that people have been fully educated on best practices in peer supports, have fully examined how these practices may impact and change current practices, and are willing to tolerate the uncertainty, the bumps, and the challenges that come with any significant change in an agency's way of doing business.

As aforementioned, it's inevitable that at some stage you will meet resistance. In most cases this is borne out of fear or lack of knowledge. The clearer you are about why and how you will develop peer roles, the more able you will be to overcome resistance and address other challenges.

A best practice is to have educational presentations and workshops on peer support directly to the executive team and Board of Directors. It is essential that this is delivered by experienced peer support workers or peer educators, in conjunction with senior management, in order to model the collaboration needed for successful implementation of peer supports. You may even wish to send some of your staff to visit or speak with different agencies already utilizing peer supports to gain a greater understanding of challenges that were met and how they were successfully addressed.

It's also helpful to conduct an agency self-assessment about your motivation for adding peer support workers. You may ask:

- What has inspired us to consider adding peer roles?
- What are the unique contributions that peer roles will bring to the agency?
- What do we hope to gain by adding in a peer workforce?

It's also likely worth asking questions like:

- What do we anticipate will be some of the challenges?
- What fears and/or worries do we have about this process?
- Where are those fears/worries coming from and what might we do to address them?

Your answers to these questions can give you some indications about your readiness to incorporate peer roles. If you struggled with answering any of these questions (or had a lot more to say about the second three than the first), it would be good to get more information and do more evaluation before taking the step to begin the implementation process.

Creating a Culture of Respect

One important early step for administrators is to prepare existing staff to welcome people in peer roles to the workforce. In order to adequately do this, administrators will need to explore the attitudes of existing staff about how they feel about adding peers to the workforce. Not all staff will be open, and some may believe that their new co-workers are not qualified to provide support. Additional concerns about boundaries and how the agency will handle potentially hiring people who also receive services through the agency will need to be addressed in revising old policies or creating a new policy.

To foster a more accepting agency culture, administrators should schedule readiness training. The following is a segment from the publication "Consumers in the Mental Health Workforce" describing the process for fostering acceptance:

- Inform all staff of the agency's plan to hire peers and explain the rationale and anticipated benefits;

- Administrators also can point out the likelihood that non-disclosing consumers and family members already serve as staff and add to the richness of the organization;

- Anticipate and be prepared to respond to questions about confidentiality, dual relationships, ethics and Americans with Disabilities Act;

- Provide a series of open and closed forums that allow staff to discuss their concerns without fear of reprisal; and

- Invite peers and staff to participate in the planning and/or problem solving of issues.

Four other workplace strategies for promoting tolerance and appreciating diversity are:

- Acknowledge that conflict is likely, and address it directly during orientation and training of new employees. Employers should have clear expectations for respect and acceptance for all individuals.

- Create an environment where everyone feels comfortable discussing their discomfort and difficulties viewing people in peer roles as colleagues.

- Support peer supporters to develop an approach that educates and promotes acceptance without breaching their privacy (Zipple et. al, 1997).

- Identify champions at all levels of the organization. A champion is someone who is very supportive of implementing peer roles and is able to discuss any concerns raised by other staff. Without a champion (or two), your implementation process may be significantly compromised.

Sidebar: Is it Best Practice to Hire People into Peer Roles at the Same Agency Where They Also Receive Services?

Often, this is not a recommended practice, and it can certainly raise complications not found in environments where this does not occur. However, the answer really isn't as simple as a clear 'yes' or 'no.'

Some of the worries about hiring someone who also receives services include:
- Negatively impacting that person's relationship with their existing providers at the agency (especially if the job doesn't work out)
- Difficulties protecting that person's privacy (e.g., if their file is accessible to their co-workers)
- Diminished ability to act as an advocate due to dual relationships (e.g., When someone is in a position to advocate for a change in treatment for someone they're supporting to a therapist or psychiatrist that they also see privately)
- Increased tendency on the part of employers to hire people receiving services because they're fond of them or want to help them out with their own rehabilitation process (regardless of whether or not they can do the job well)

The list goes on, but there's also the other side of the story. For example, in more rural areas, such policies against hiring someone who receives services may eliminate their potential to find work in a peer role at all. Additionally, sometimes 'use of services' is quite broadly interpreted. For example, someone may periodically use crisis services in an organization because that is the only organization that offers those services in their area, but generally not be connected.

Additionally, some would argue that it's a valuable show of being human to acknowledge and receive services right along those you're often supporting. Others would add that it's a product of a more conservative belief system to think that those worlds must be kept separate, and that it re-enforces shame about getting help to do so.

Certainly, regardless of what we believe, many people are successful working in peer roles in an organization where they have or currently receive services, while others have experienced conflict or difficulty.

Note: It should not be assumed that all people working in peer roles will currently be receiving services at all!

Stage 2 of Implementation: Policy Review and Readiness

Recovery oriented services, including peer workers, can only be successful if the policies of the agency align with the recovery orientation. It is necessary to:

Review policies/vision/mission/values – Do they incorporate a full recovery vision? Do the activities allowed under the policies align with dignity of risk, self-directed care and other core components of a recovery-oriented system? Is documentation recovery-oriented or deficit-based?

Review human resource policy and procedures.
A. Do HR professionals fully understand the peer worker role? Do they (or whoever will be responsible for initial hiring) know how to interview people to determine which applicants are best suited for the job? Is there a job description that clearly articulates the roles and responsibilities of the job? (See below for further discussion)

B. Do HR workers have familiarity with Social Security benefits in order to guide new employees about how any agency benefits may interface with SS benefits?

C. Are the HR staff fully apprised of ADA policies with respect to psychiatric diagnoses? Have the essential functions of the job been identified? Have reasonable accommodations been considered?

It's worth noting here that most well-prepared organizations will develop Human Resource policies that are compassionate, but consistent across all positions, not just peer roles. It is critical that people working in peer roles still be held accountable for actually doing their job, and doing it well. Employers should not confuse lowering performance expectations for reasonable accommodations.

Identify appropriate supervisors
Supervision typically has two components: administrative and professional development. Administrative supervision deals with things such as the needs of the agency (paperwork, etc.), employee benefits (vacation time, etc.) and other "administrative" concerns of the employee. Professional development, on the other hand, evaluates how well the person is using his/her professional skills in the work environment, may offer tips from a more experienced practitioner, brainstorms ongoing training needs, and in general, supports the employee to continue to expand his/her professional expertise.

In order to meet these standard supervisory goals, it is imperative that peer workers receive at least the professional development component of supervision from a more experienced peer worker,

as it's just not feasible for someone from a different profession who has never functioned in a peer support role to guide this needed professional development.

If you are just beginning to implement a peer workforce, you may not have a more experienced peer specialist on your staff, although you should keep this in mind as you do your initial hiring. However, if you do not have someone on-site, you can consider looking to other agencies in your area or your local peer-run agency to see if you can contract for supervision support. Even supervision via Skype from individuals working in further away organizations can be better than nothing. If there are local Peer Networking groups (where individuals in peer roles across several organizations gather), this can be another source where a new peer worker in your organization can get support and/or find someone who can fill that role in a more ongoing way.

Supervision is crucial to the success of the peer support workforce and, ultimately, the agency as a whole. Supervisors must be "champions" of developing the agency peer support workforce.

Assuming you've hired an experienced peer support worker to take on the role of supervisor, he or she should be offered training on how to supervise peer workers, as this is not typically covered in a Certified Peer Specialist training class. On-line

Sidebar: What's harder—Supervising 'peer' or 'non-peer' staff?

It's extremely important to not assume different standards for people working in peer roles verses those working in other positions throughout your organization. Having the life experience of being given a psychiatric diagnosis and receiving mental health services is not a strong predictor of trouble to come. Consider this brief quiz from someone who has had the experience of both supervising a team of people who do NOT identify as 'peer' workers and those who do.

1. In which environment have I had to address issues of serious and habitual lateness:

    A. 'Peer' environment
    B. 'Non-Peer' environment
    C. Neither
    D. Both

2. In which environment have I had employees just not show up for a shift?

    A. 'Peer' environment
    B. 'Non-Peer' environment
    C. Neither
    D. Both

3. In which environment did I have an employee who killed themselves while on personal leave?

    A. 'Peer' environment
    B. 'Non-Peer' environment
    C. Neither
    D. Both

4. In which environment did have I had employees who have taken leave time for emotional/mental health related reasons?

    A. 'Peer' environment
    B. 'Non-Peer' environment
    C. Neither
    D. Both

trainings are available (e.g., through the Transformation Center here: http://transformation-center.org/home/training/certified-peer-specialists/cps-supervisor-training/).

Supervising people in peer roles is, in most ways, exactly like supervising non-peers. Effective supervision is critical for successful employment of persons in recovery. After recruiting, hiring, and orienting a new employee, any ongoing issues such as job and role clarification, expectations, and performance; confidentiality; disclosure; dual roles; and working as a team member can be readily addressed in supervision (Gates and Akabas, 2007)

It is important that supervision is a dynamic process by which the peer-support worker is helped by the designated responsible staff person to make the best use of knowledge and skills so as to perform the requirements of the position effectively. In this context, the purpose of supervision is to help the peer staff to be resourceful and effective in performing his/her work duties (i.e., the position requirements and duties of a peer-support worker).

Supervision works well as a reflective process whereby the supervisor helps the peer-support worker to examine his or her performance and continue to develop and refine his or her abilities to perform duties

Sidebar Continued: What's harder— Supervising 'peer' or 'non-peer' staff?

The answers are as follows:

1. In which environment have I had to address issues of serious and habitual lateness:

    D. Both

2. In which environment have I had employees just not show up for a shift?

    D. Both

3. In which environment did I have an employee who killed themselves while on personal leave?

    B. 'Non-Peer' environment

4. In which environment did have I had employees who have taken leave time for emotional/mental health related reasons?

    D. Both

That said, people being hired into 'peer' roles *are* often more likely to have a more limited work history (or be just coming back from a lengthy break). They are also more likely to be struggling with the ins and outs of managing social security and employment income which can be very stressful and, at times, scary. Additionally, people working in peer roles may be more likely to have experienced extreme trauma in their lives (though, certainly, they are not alone in that). Finally, they are more likely to have experienced trauma within the mental health system, and to feel 'alone' in their new jobs because they are the only one (or one of a few) working in a role that others might feel challenged by. For all of these reasons, it is possible (and even likely) that you may experience increased or new challenges in supervision of your workforce.

However, the most well-prepared organizations will look to revise their Human Resource policies so they offer room to be fair and compassionate to *all* employees across the board. They will not have separate ways of responding to people in peer and non-peer roles, and if there is increased difficultly, one of the things they will be willing to look at is what in the *work environment* is making the job hard to do or sustain.

as effectively as possible. This is where clear job descriptions and regular performance measures are important. (See below for further discussion)

The supervisor is responsible for creating an environment for learning and growth. The following supervisory tasks are used to accomplish this goal:

- Create a supportive environment in which the peer-support worker is encouraged to learn and develop the capacity to apply and refine skills;
- Promote a stimulating environment that involves questioning and reflective practice;
- Help the peer-support worker to identify strengths and areas for growth and set goals to develop and refine skills and abilities;
- Treat the person as a mature, adult worker. Be willing to give constructive feedback.
- Ask for constructive feedback from the peer worker.

In states where peer roles have become Medicaid reimbursable, Medicaid Regulations require that peer-support workers be supervised by a master's level mental health professional. This person can easily fill the role of administrative supervision. But even in this case, it is imperative that the person understands peer values and the role of peer-support workers.

Supervision is not support, but supervisors can provide supervision supportively. The supervisor can make the peer-support worker feel comfortable in the work environment, so as to see it as a learning environment as well. The effective supervisor will help the peer-support worker draw on personal experience and focus on developing relevant skills to meet the requirements of the job.

It is important to understand that the supervisor is not a therapist for the peer-support worker. Supervisors do need to be available to provide direction and assistance with job duties, provide feedback regarding job performance, lead team meetings, and handle other relevant issues.

Step 3 of Implementation: Developing a Timeline

Prior to implementing peer support, take the time to plan. Assess your workplace and its readiness for peer support, develop a plan of action that needs to be taken, assign responsibilities and set realistic timeframes. It is no good saying that this will all happen within a month or so. The workplace needs to be prepared, as it is a change. This must be a thoughtful process with a well-developed plan of action.

Take this short quiz to help you as you assess how long this process should take. Circle 'T' if the statement is true, and 'F' if the statement is false.:

1. There are multiple people in your organization who understand and support moving forward with implementing peer roles.   **T   F**
2. Several of the people who support moving forward with peer roles in your organization are in key supervisory roles. **T   F**
3. You have identified how you will support adding peer roles in your budget. **T   F**
4. There are several other organizations in your area that have already implemented peer roles and that you can look to for support and consultation. **T   F**
5. There's a local peer-to-peer organization in your area that you can look to for support and consultation. **T   F**
6. Your organization has already been doing a lot of work to move toward more recovery-oriented values and approaches. **T   F**
7. Your organization has already been periodically sponsoring (or co-sponsoring) events that involve discussions of alternative perspectives and/or presentations from people who have experienced psychiatric diagnosis, trauma and other significant life challenges. **T   F**
8. There are one or more local organizations offering well-respected trainings for people   working in peer roles. **T   F**
9. One or more employees in your organization have attended trainings (webinars, conferences, etc.) to learn more about the ins and outs of the peer role, supervision of peer roles, etc. **T   F**
10. You have developed an advisory board that includes multiple people who receive (and/or have received) your organization's services to be a part of this process. **T   F**

8 to 10 'True's: You really are just about there! However, you should still plan on at least six months to get the final pieces in place.
5 to 7 'True's: It sounds like you've been laying some important pieces to the foundation of this process, but you've still got some work to do. Create a plan of at least one year.
Less than 5 'True's: You may have made some moves to start getting ready, but there's still work to be done. Reach out to other organizations (even if not local) to see how long their process took.

If the implementation of peer roles is on a timeline that is outside of your control (e.g., a funder is requiring you to do so), then here are a few options to consider to speed up your 'getting ready' process:

1. **Send a couple of key employees to national conferences focused on the 'peer' role.** Examples include Alternatives or the International Association for Peer Supporters conference. Both are offered annually and within the United States. While the material and workshops they offer may vary in quality, you will inevitably find yourself surrounded by people working in peer roles and lots of information along those lines.

2. **Plan a trip to visit organizations that are known for their work in this area.** Even if such a trip takes you out-of-state, it can be well worth your time. To find out about places that might be worth visiting, check the websites of places like the National Empowerment Center (www.power2u.org) and the National Mental Health Consumers' Self-Help Clearinghouse (http://mhselfhelp.squarespace.com/) both of which are national technical assistance organizations specializing in focus on the development of peer roles.

3. **Consider sub-contracting to another organization.** **This** option may be especially   worthwhile if you live in an area where there is a strong peer-to-peer organization nearby. The way it works is you sub-contract a particular dollar amount to that organization, and they provide you with someone to work in your organization for an agreed upon number of hours each week. That organization also generally takes on oversight of hiring, training and supervision. The major benefits of this approach include that it often frees you up from having to require the person working in a peer role to do things that would conflict with their role (like take routine notes or attend certain trainings) that they'd otherwise be   required to do if they were your direct employee. You are also often getting two for close to the price of one, because the supervisor of the person often essentially ends up (directly or indirectly) consulting to your organization, as well.

Peer Work: What Does It Actually Look Like?

Peer Support Competencies

Like most professions, peer workers have different levels of training and expertise, but also some basic competencies that carry across all peer worker positions.   For example, in nursing, someone might be trained as a licensed practical nurse (LPN) or a registered nurse (RN). While there are some differences in their roles, all nurses provide general patient care, administer medication, etc.

Currently, the "Certified Peer Specialist" (sometimes called a "Recovery Coach," particularly in circles where the focus is on peer-to-peer support for people in addiction recovery) is the only credential found in most states. However, each state creates its own training and certification criteria and process, and there are no national standards. Some states have also instituted separate credentials for peer specialists who work with people experiencing both emotional and substance abuse-related distress, peer specialist supervisors, and specialty area peer support credentials, e.g. forensic or employment peer support.

However, this lack of organizational structure for peer support specialist roles doesn't mean that we don't fully understand the core competencies. As noted above, peer support has a long history in the community, and the current phase of development is simply a fine tuning and expansion of understanding, rather than re-design. The history and values provide a clear road map as to what peer supports should look like.

A competency is "the capability of applying or using knowledge, skills, abilities, behaviors, and personal characteristics to successfully perform critical work tasks, specific functions, or operate in a given role or position" (Ennis, 2008, pp. 4-5).   These are gained through experiential and academic learning, as well as through factors that may be beyond the person's control, such as talents and gifts with which someone may be born. For example, some people are naturally extroverts and may be more comfortable in a "people" field than another.

Professional competencies typically cover a range of areas that go from general to specific. At the general end of the continuum are the general worker competencies required of everyone. The most specific end of the range would include the competencies needed for someone entering the specific profession. What follows on the next page is what this looks like for someone in a peer role.

**Peer Support Workforce
Competencies**
Ability to use own experience to inspire hope
and belief in recovery; Support self-
determination through connections from a mu-
tual stance; Facilitate self-exploration and dis-
covery, etc; Act as a change agent to support
environments, systems and approaches to move
forward.

**Recovery Oriented Mental Health
Workforce Competencies**
Ability to work with people from a strengths
perspective, support people's recovery
process, support dignity of risk, etc.

Mental Health Workforce Competencies
Ability to work with people respectfully, navigate
regulations, recognize roles of different workers, work
independently, etc.

General Worker Competencies
Ability to get to work on time, interact with other co-workers and
supervisor, pick up on the cultural norms of the agency, commu-
nicate needs & respond to others' communications, etc.

As we discuss competencies for the peer worker roles, we will be focusing on the profession-specific competencies, and will not articulate those general competencies required of all workers. Hence, we will be looking at what people in that role need to know be able to successfully fulfill the role.

Unfortunately, there is no nationally endorsed or even state endorsed competencies available to draw upon. Legere and Nemec (2011) sought to create a list of competencies by creating a comprehensive list of stated competencies from CPS trainings offered across the country, as well as the North Carolina Role Delineation study. A list of 170 competencies yielded zero competencies common to all programs and only one competency that crossed over 10 of the 11 reviewed trainings. Further analysis of the listed competencies revealed that few were specific to the field, most were general recovery-oriented competencies, and some were, frankly, disrespectful to the peer worker professional.

Generally speaking, there are three competency areas that stay true to the historical role of peer support: 1:1 peer support, being a change agent, and working from a stance of being "in" but not "of" the system.

Competency Area	Related Knowledge*	Related Skills*
Peer Support	Knowledge of 'peer' movement	Ability to incorporate 'peer' movement values into work, including stories of lived experience
		Understanding the historical context of injustice, including outdated cultural beliefs and treatment practices, and the value of a peer support relationship that validates and empowers.
	Knowledge of 'peer' principles	Ability to support people from a mutual perspective by sharing lived experience
		Ability to support empowerment and self-determination
		Ability to convey information in every-day, non-clinical language
		Ability to relate to the experience and challenges of the person using services as a result of own life experience
	Self-determination	Having faith that each person intrinsically knows which path towards recovery is most suitable for them and their needs, noting that it is their choice whether to become involved in the peer support relationship.
	Empathic listening	Active listening skills (paraphrasing, open-ended questions, etc.)
		A personal demeanor that is warm, empathic and non-judgmental, demonstrating a genuine interest in the person being supported and valuing that person as an equal and a whole person

* *A partial list*

		Interactions that respect the person's right to self-determination and empower the person to explore options and co-create new ideas rather than providing advice or having a personal agenda.
		Tolerating uncomfortable feelings
		Tolerating silence
		Recognizing the impact of non-verbal communication and the environment in creating a welcoming, comfortable, non-judgmental interaction.
	Supporting dream-centered life planning	Supporting exploration of dreams and hopes
		An ability to know when to share aspects of one's personal life experience in a manner that provides relevant insight and/or hopefulness while keeping the focus on the person being supported.
		Role model recovery& discovery
		Communicate a sense of hopefulness and a strong belief in the possibility of recovery
	Community resources	Support people to find meaningful connections in the community, e.g. peer groups, religious organizations, etc.
		Support access to housing, employment and other valued community settings.
		Support access to and utilization of alternative approaches to recovery, e.g. acupuncture, healing in the arts, etc.
	Knowledge of the Social Determinants of Health	Support people to identify and utilize useful wellness tools
		Recognize the relationship between the social determinants of health and their impact on mental health and wellbeing
	Group Facilitation	Facilitate peer recovery groups, such as "Alternatives to Suicide" or "Hearing Voices Network" groups.

	Diversity and Inclusion	Recognizing the impact of social exclusion on an individual's recovery and supporting the person's steps toward participating in community life
		Ability to recognize social injustices that are inherent in society relating to social factors such as race, culture, sexual orientation, class, disability, and others, and how these can affect the person using services and the peer support relationship
		Recognizing that each individual has a unique perception of the world and that there is no one way to approach life's challenges
Change Agent	Knowledge about organizational change	Use of lived experience to inspire hope about recovery to those providing services
		Use of snippets of lived experience to demonstrate point(s) related to system change
	Hope and Recovery	Acknowledging the power of hope and the positive impact that comes from a recovery approach
	Knowledge of recovery approaches and how this holistic, person-driven approach complements a purely clinical approach to mental health	Ability to model and teach everyday non-stigmatizing, non-clinical language
		Ability to recognize system components that contradict a recovery oriented model
		Ability to respectfully engage others in conversation about areas that might need to be changed
		Ability to gather allies to the cause and strategically effect change

	Knowledge of recovery literature, including outcomes of peer supports	Ability to incorporate data with lived experience to motivate change in agency policy/procedures
	Knowledge of conflict resolution approaches	Ability to approach difficult topics in a way to diffuse conflict and allow for meaningful consideration by all parties.
Be "In" but not "of" the system	Knowledge of power dynamics and patterns of oppressed becoming oppressor	Ability to validate personal power in peer role and avoid allure of power in more clinicalized version of peer role.
		Ability to identify when power struggles are creating barriers to good services
	Knowledge of human experience recovery language	Ability to communicate in everyday, non-clinical language, rather than taking on the language of the system.
	Knowledge of "trauma informed" and "trauma sensitive" approaches	Ability to communicate when practices are retraumatizing, using one's lived experience to demonstrate the point whenever possible.
		Recognizing the prevalence and impact of trauma on people receiving mental health services and its implications for recovery and healing
		Understanding how healing can occur through healthy relationships, such as peer support, that honor mutuality, equality and the freedom to openly share one's story
	Knowledge of the CPS Code of Ethics	Ability to stay true to the Code of Ethics by supporting self-determination for people, even when this goes against the wishes of the team.
		Confidentiality, reliability and ethical behavior are honored in each and every interaction
		A degree of self-confidence and initiative, coupled with a desire to learn from others, that results in an ability to both give and receive opinions and a commitment to work through whatever challenges might arise

Is that really part of a 'peer' role?

Peer roles can come across as very abstract at times. In spite of the lengthy list of competencies and skills through which you just read, it can be hard to picture what it all really looks like. What constitutes a 'day in the life of a peer worker?' For better or for worse, there really is no such thing because peer-to-peer support is so fundamentally based in genuine human relationships that are flexible and based on that particular connection.

However, another way to look at understanding peer roles is to have a grasp on what they aren't or what tasks should not be included. Below is a chart designed to help build understanding in that way. In fact, this section is so important that we printed it twice: Once in the section directed toward people working in peer roles and once in the section for providers.

Whether or not a task is consistent with a peer role can become a complicated question, especially when it's wrapped up in issues of limited budget and limited understanding of the peer role itself.

There are three main categories of work that is not consistent with peer roles fits into. These include:

• **Busy Work:** Is this just busy work because you don't know what else to do with a peer worker and/or there is no one else who wants to do a particular task? Are you not recognizing the special skills and training that a peer worker has, and giving them only the tasks that anyone could do?
• **Agenda:** Are you asking the peer worker to focus on a particular agenda (other than that of the person they're supporting)? Are you seeing them mainly just as a way to get information for the rest of the team? Are you seeing their activities as defined by provider paperwork like treatment plans?
• **Power Imbalance:** Are you asking the peer worker to do something that will increase the power imbalance (or perception of power imbalance) between them and the person they're supporting?

Activity/ Topic	Consistent with Peer Role	Not Consistent with Peer Role
Medications	Supporting someone to evaluate and communicate their concerns and desired changes regarding medications; Supporting someone who is withdrawing from medications to come up with other supports; Supporting someone to gather information/resources pertaining to meds; Supporting someone to come up with a plan toward independence with med management, changes, etc.	Administer medications; Become certified in the Medication Administration Program (MAP); Use your own lived experience to encourage someone to comply with their medication orders; Report back as to whether or not someone is taking their medications, etc.

Activity/Topic	Consistent with Peer Role	Not Consistent with Peer Role
Fund Management	Work with someone to build skills (balancing their checkbook, etc.); Work with someone to come up with a plan to regain independence of their funds; etc.	Become someone's representative payee; Make decisions about how someone can and can't use their own funds; Any other fund-related activity that is likely to be seen as coercive or having control over the person's money
Giving Rides	Because the person trusts you and wants you to go with them; Because you're trying to build a relationship with the person and offered to give them a ride; Because you're going with the person to advocate/support them at an appointment	Because everyone else has something more 'important' to do, so you've become a taxi driver; Because they hope you'll convince the person to do/not do something on their way to an appointment; Anything else that comes across as using you routinely as a taxi
Cleaning Someone's Apartment	Because the person trusts you and asked you to help; Because you're trying to build a relationship with the person and offered to help	Because everyone else has something more 'important' to do, so you tend to get assigned the tasks no one else wants to do; Because the provider thinks you've got the best chance to talk the person into changing their cleanliness habits; Because cleaning is in their treatment plan, and someone's got to do it whether or not that person wants to
Assessments	Support the person to collect their thoughts and have their voice heard in the process; Support the person to understand what is written about them; To be present while the assessment is happening as a support person	Giving your opinion about how the person is 'functioning'; Completing written assessment paperwork
Treatment Plans	Supporting the person to get their voice heard during the treatment planning process (by being present, helping them plan before the meeting, and/or advocacy); Supporting the person to change their plan as desired; Advocating to keep treatment goals that are not self-identified or are otherwise inconsistent with a recovery-oriented approach out of the plan	Writing a treatment plan; Focusing 1:1 interactions with the person around what they're supposed to be working on according to their treatment plan; Writing routine progress reports on treatment goals

Activity/Topic	Consistent with Peer Role	Not Consistent with Peer Role
Meetings	Advocating to not talk about the person without them; Supporting the person to be present and heard at treatment team meetings that pertain to them; Supporting the person to gather information and understand the content of meetings; Asking clarifying questions at meetings to support understanding; Meetings that are about policy setting, establishing overall best practices, etc.	Routine attendance at meetings where individuals are being discussed without them being present; Giving your own opinion about what should happen with someone (particularly where it is not consistent with that person's own desires)
Forced hospitalization/ Commitment Hearings	Advocate for the person's voice to be heard in the process; Stay with them as a support during meetings, assessments and while waiting; Help them gather information, understand what is happening and what is likely to happen next; Help them understand their rights; Help them get personal belongings that they're asking for; Help them make plans for taking care of pets, bills, etc.; Help them present WRAP plans/Advanced Directives to relevant personnel; Helping to educate their lawyer; Helping them plan what they will say when testifying on their own behalf; Accompanying them to court; Testifying as an advocate if you think your testimony might help offer support/educate the court	Transporting forced hospitalization paperwork; Testifying against the person; Making your own recommendations to the court/lawyers (especially when inconsistent with the person's own wishes)
1:1 Visits	When they are requested by the individual (or when you offer and they accept); When you and the person have a mutual agreement to meet at the same time each week; When you are open to talk about/do whatever makes sense for where that person is at in the moment	When the provider wants you to visit, even if the person tells you no; When the visit is focused on treatment plan goals (unless at the individual's request) or trying to get someone to do something they don't want to do

Activity/Topic	Consistent with Peer Role	Not Consistent with Peer Role
Reading files and treatment plans	When you are supporting the person to know what is in their file; When you are supporting the person to understand their current treatment plan; When you are supporting the person to seek to have something added/removed/ changed in their file	When the provider has asked you to read the files as a part of a routine; When you are reading the file as a way to get to know the person
Job searching	When the person has asked for your help; When you are sharing some of your own wisdom gained in from your own job searching process; When you and the person have agreed to work together to look for employment resources, etc.	When your employer has told you that employment needs to be the focus; When you are focusing on employment only because it's in the treatment plan
Housing search	When the person has asked for your help; When you are sharing some of your own wisdom gained in from your own home searching process; When you and the person have agreed to work together to look for housing resources, etc	When your employer has told you that housing needs to be the focus; When you are focusing on housing only because it's in the treatment plan
Answering Phones	When you're just occasionally helping out around the office because you happen to be there; When it's your own phone that you're answering; When you're answering a line that is designated for peer-to-peer support calls only	When you're routinely answering the phone because no one else wants to; When answering the phone means you are reasonably likely to find yourself in a position to have to assess or 'triage' calls for level of crisis and transfer to clinicians
Filing	When you're just occasionally helping out around the office because you happen to be there; When it's papers from a project or training you are personally working on/organizing	When the papers contain personal information about particular people; When you're routinely filing because no one else wants to
Social Events	When it's a part of your relationship building; When you're supporting someone to explore things they have fun doing; When you're supporting someone to get to know community resources or other people; When it's just something you both agreed you wanted to go do	When it's all your ever asked to do (i.e., the 'peer' role has been minimized to being purely recreational); When you're asked to take someone somewhere who doesn't want to go there or doesn't want to go with you

Is that Really a Part of the Peer Role?: The Why of It

Medications (Power Imbalance): Whether medications are good or bad, wanted or unwanted, handling someone else's medications is a tricky thing to do. First of all, there's a history of coercion and force around medications that is relatively undeniable, no matter where you stand on other related issues. In fact, many people currently being supported in the mental health system are under some degree of force to take medications. As people working in peer roles are tasked with working on as equal of a playing field as possible with people they're supporting, getting involved with meds can immediately throw that goal off based on the history alone. Perhaps more importantly, for every 'privilege' that someone working in a peer role has, that someone receiving supports does not, the barrier between them gets bigger. That is to say, if someone in a peer role is administering medications, that is because the person receiving them does not have the control or access to do it themselves. Thus, at least in part, it's not even about the fact that we're talking about medications or anything else. One of the main issues is that of privilege, and there is nothing positive to be gained by increasing power imbalances in a relationship that is supposed to be as free of power imbalances as possible.

Fund Management (Power Imbalance): Similarly, there is a history of loss of power and control in the realm of representative payeeships. There is little that can throw off power imbalances further than having access and control over someone else's funds. This simply doesn't work within the context of a peer-to-peer relationship.

Giving Rides (Busy Work): This one is tricky for another reason. That is because giving someone a ride in a way that is consistent with peer-to-peer values can look very similar to when it is not consistent. Really, it comes down to this: Is the person in a peer role being used as a taxi to drive around people with whom they do not particularly otherwise have a relationship?   Did the request come from the individual needing a ride or from a boss delegating responsibilities? Is it occasional or routine? Is the peer role being valued overall? There's nothing to say that someone working in a peer role can't occasionally help out in a pinch by giving someone a ride. However, if they are routinely used in this way that is a clear sign that their role isn't being valued, because if it were, they simply wouldn't have the time.

Cleaning Someone's Apartment (Busy Work/Agenda): Similarly to the 'giving rides' topic, this one can go either way. If someone has asked the person in a peer role to help out, that's great and up to them to negotiate with one another. However, if a boss has asked, then it's an issue, especially if it's frequent. In some ways, it's an even bigger issue than the rides one, because entering someone's home and touching their personal belongings can feel very personal. Thus, doing this in a way that is not invited by the person themselves can violate any existing or future trust needed for actual peer-to-peer support to occur.

Assessments (Power Imbalance): Participating in assessments is problematic for two reasons. First, people working in peer roles are trained to steer clear of judgment and talking for people as much as possible. Stepping into an 'assessment' role immediately pulls them out of that place. Perhaps more importantly, part of the point of the peer role is to support the person's voice to be heard. People receiving mental health service often report not feeling heard or like their voice holds no credibility in a room full of clinicians. Although someone in a peer role generally isn't seen as having the same credibility as a clinician, they are typically seen as having more credibility than the person they're supporting simply by virtue of the fact that they are a paid employee. Thus, if the person in a peer role begins participating in the assessment process, they become just one more person whose voice is being heard louder than the one the assessment is about.

Treatment Plans (Power Imbalance/Agenda): Responsibility for writing a treatment plan about someone is an incredibly powerful role. While it can be done both poorly and well, it still creates a power imbalance even under the best of circumstances. Additionally, many treatment plans are subject to pressures from system expectations and so it can be very difficult to keep other agenda from seeping into provider plans.

Meetings (Power Imbalance): There is little in this world that can leave someone feeling more powerless than knowing there is a meeting taking place about them without them present. As such, it becomes a position of power and privilege for a peer worker to be present in those situations. In a way, it also makes the peer worker complicit with the practice of talking about people in this way which can also be seen as a violation of trust.

Forced Hospitalization/Commitment Hearings (Power Imbalance/Agenda): Although it's somewhat unusual for peer workers to be asked to be involved in these activities from a provider perspective, it does happen. For example, there are people working in peer roles who report having been asked to take commitment paperwork with them to the hospital when they're on their way to support someone who very much does not want to be forced into the hospital. Some have also reported being asked to testify at commitment hearings in ways that are not consistent with what the person they're supporting wants. These actions represent not only a power imbalance and focus on an agenda that is other than that of the person being supported, but they will also been seen by most people as clear signs of dishonesty and breach of trust.

1:1 Visits (Agenda): Visits one-to-one between a peer worker and someone they're supporting can be really powerful and important times to build connection and explore issues. However, when they occur because the provider wants them (as opposed to the individual themselves), or when they're constructed around the need to accomplish specific treatment plan goals, control over the agenda gets lost. It's critical to the essence and potential impact of the relationship between a peer worker and the person they're supporting that the connection be seen as something that they together own and control. When others step in with outside agendas, it defeats that.

Reading Files (Agenda/Busy Work/Power Imbalance): One of the most common reasons people are asked to read files during their training period is for lack of anything else for that person to be doing in that moment. Other common reasons include that it is simply standard practice ("the way it's always been done") to ask someone to read the files of people with whom they'll be working. Additional and well-intentioned reasons include wanting to make sure that people know any historical issues that might be of current concern, and so on. However, learning about someone through the provider's eyes clearly orients someone to the provider's agenda and ways of interpreting various events and experiences. It's also a clear power imbalance for the person in a peer role to have that level of access of information to the person they're supporting, when the person they're supporting has no information about them.

Job & Housing Searches (Agenda): Does the person see job or housing searches and related skill building as a priority? Do they see you as a person they trust and want to work with on that priority? If yes, then great. If not, then the peer worker is being pulled into someone else's agenda.

Answering Phones (Busy Work/Power Imbalance): Is there any reason for someone in a peer role not to pick up the office phone? No, there's no blanket reason, and if it happens once in a while that's fine. However, there is a reason to not station them in that role—several, actually. First, it's just not a good use of time and if it happens regularly, it suggests that the peer role isn't being used well at all. It's even more important that it not happen, however, when people who answer calls are expected to 'triage' them. This puts someone in a peer role in a position to have to 'assess' the needs of the person calling, which puts the person in a peer role in a power position and just simply isn't consistent with the intended focus. One final consideration: If a person in a peer role is answering the office phone, that necessarily means they are in an office. That's not inherently wrong, but if it is often the case, it suggests that that person isn't spending enough time where they really should be: with people in the community. Even being in an office with staff is indicative of a power imbalance that can damage the formation of relationships.

Filing (Busy Work/Power imbalance): Again, there's nothing wrong with helping out once in a while, but it shouldn't be a regular thing or it becomes busy work. It also shouldn't include confidential information, as access to clinical files represents a power imbalance. If the information that needs to be filed is information someone receiving services could also handle, then there's nothing wrong with a once in a while thing.

Social Events (Busy Work): Social events can be a great way to connect, but we've also heard people and organizations speak about peer roles as if 'social outings' are their main focus. Going out for coffee, to a concert, etc. can be a great way to build a relationship, but if the social outing is the end focus even over the long-term, it may just be busy work.

Developing a Job Description

While job descriptions are important for all employees, they are especially important for peer workers due to the newness of the role. The job description becomes the blueprint for the employee, the supervisor and other staff with respect to the expectations, tasks and functions of the role within your agency. A well-written job description is critical to being able to attract, hire, and sustain a well skilled peer workforce. A vague job description, on the other hand, lends itself to uncertainty, miscommunication, assumptions, misunderstandings and, frequently, dissatisfaction by both the employer and the employee.

Components of the job description:

Function:
Summarize the main purpose of the position within the department/organization in one sentence.

Reporting Relationships
Describe the "chain of command" and the types of supervision the employee will get and/or give, indicating the specific job titles of the supervisors and the positions supervised.

Responsibilities
List 4 to 6 core responsibilities of the position and identify several specific duties within each of the core responsibility areas.

Qualifications/Competencies
List required and preferred qualifications, credentials, and competencies in order of importance. These might include educational requirements (e.g., a high school diploma or equivalency), training or certification as a peer specialist, or specify that the employee must be a person in recovery (e.g. "Be a self-identified current or former user of mental health or co-occurring services who can relate to others who are now using those services")

Employment Conditions
Describe any relevant circumstances, such as any physical requirements (e.g., standing, lifting), environmental conditions, unusual work schedule (e.g., rotating shift, on-call hours), and any other requirements (e.g.,driver's license, background check, random drug screen).

A well-crafted job description will reflect the unique circumstances and needs of your service, and the people who use it, while demonstrating and staying true to the core values of the role.

Sample Peer Specialist Job Description Components

Sample function statements
- Provides opportunities for people receiving services to direct their own recovery process (self-determination) and is an advocate for peoples' needs and rights
- Supports people in groups and on a one-to-one basis by offering recovery training and outreach to individuals who use mental health services in the community
- Shares personal recovery experiences and develops authentic, mutual peer-to-peer relationships
- Offers instruction and support to help people develop the skills that will help them reach their own desires and goals.
- Supports people to discover available service options, within and beyond the system.
- Supports people in developing a personal network of friends in the community.
- Supports people with navigating the mental health services system and exploring alternatives available in the peer and general community at large.

Sample responsibility statements
- Assist in the orientation process for people who are new to receiving mental health and/or co-occurring disorders services to inspire hope and create connection.
- Support recovery education and wellness planning, and connect to self-help strategies.
- Support people during transition periods to increase access to and utilization of community resources.
- Support people with connecting to others who may be important to the person, such as family, friends, etc.
- Support the development of problem solving skills
- Provide education and advocacy within the community to reduce misconceptions, prejudice, and discrimination against people with psychiatric diagnoses.
- Improve the team's understanding of lived experience.
- Conduct staff awareness raising and recovery training.
- Educate professional staff about the recovery process and the damaging role that certain traditional practices can play in that process.
- Improve communication between people using the service and practitioners
- Accompany people, when requested, to support access and utilization of community resources.
- Support people to take an active self-directing role in their recovery process.
- Model personal responsibility, self-advocacy, and hopefulness through telling one's personal recovery story, and the tools and strategies that support one's recovery.

- Support people in emotional distress by listening and being there.
- Support people to develop alternative strategies during times of emotional distress to reframe "crisis" responses.
- Exhibits a nonjudgmental approach, effective listening, good eye contact, and positive interactions

Sample Qualifications
- Lived experience of a psychiatric diagnosis, extreme emotional states and/trauma.
- High School Diploma or equivalent (not used in all settings, though often required for Certified Peer Specialist training programs and/or Medicaid reimbursement)
- Peer Specialist Certification
- At least 18 years of age
- Ability to share lived experience in a way that supports, empowers and brings hope
- Ability to listen with empathy, and support people to discover their own solutions
- Ability to work independently
- Ability to model and mentor recovery process
- Ability to assist in the development of a culture of recovery.
- Knowledge of community peer and alternative resources to support community integration

In developing a job description, be aware of the need to allow flexibility for the role to develop in a way that harnesses a peer workers individual experience and strengths. Statements similar to those above will allow for that flexibility.

Also be aware of job responsibilities that are not consistent with peer roles. For example:

- It is not ideal for people working in peer roles to attend staff meetings where individuals are routinely discussed without their being present. (This is not consistent with efforts to avoid power imbalances or respect movement values.)
- It is not consistent for people working in peer roles to be involved with medication delivery, medication administration trainings, or representative payee relationships (other than supporting the individual to have a voice in how these are all set up and to be educated about their rights and other relevant information involved with working toward independence)
- It is not ideal for people working in peer roles to be involved with routine note taking, and especially not assessments or treatment planning (again, these interfere with avoiding power imbalances and remaining 'in but not of' the system)

It's also important to be careful about language used in job descriptions (and job ads) for peer roles. As one of the peer worker's roles is to use and move the organization toward more non-clinical, non-labeling language, it can be confusing if their whole job description is full of "mental illness" and other clinical words, and so on. Once you have completed a draft, it can be a really good idea to run it by someone who has experience with hiring for peer roles and/ or other people who have used services in (or outside of) your organization.

Overall, in developing a job description, be aware of the need to allow flexibility for the role to develop in a way that harnesses a peer worker's individual experience and strengths. Statements similar to those noted on the previous pages will allow for that flexibility, and help you to create a framework within which to build understanding and potential.

See the next few pages for actual sample job descriptions from organizations that have successfully implemented peer roles. While these job descriptions are not necessarily 'perfect,' they each have strong elements that other organizations may wish to draw upon.

TITLE: Peer Coordinator

PROGRAM/DEPARTMENT: CBFS Programs

REPORTS TO: Vice President of Adult Services

DATE: 9/22/14

POSITION PURPOSE AND OBJECTIVES:
The Peer Coordinator provides coordination and support for the Peer workers in all CHD CBFS Programs. S/he supports the Peer Workers in providing trauma-informed peer support that is directed by the core values of the Program. S/he also provides direct support to people served by the CBFS program when needed. The peer staff operates with the ultimate goal of empowering each individual to find his/her own path to recovery.

ESSENTIAL JOB FUNCTIONS:
Coordination of Peer Services
- Facilitates a regular support meeting of all CHD peer staff.
- Attends CBFS; CHD; DMH area; and state-wide meetings as needed
- Coordinates an assessment of CHD's and CHD subcontractors' current Peer Worker models
- Helps develop current and future models of peer work in the CHD CBFS programs.
- Provides support and training for Peer Staff and Program Staff around Recovery and other related subjects.
- Works closely with program management to support Peer workers

Role Modeling and Leadership
- The Peer Coordinator models coping, self-help and self-advocacy techniques that may include wellness management tools such as the Wellness Recovery Action Plan (WRAP)
- The Peer Coordinator shares his/her own recovery story, including points of self-empowerment and successful community living, in group and/or individual support settings as appropriate for the work situation while balancing the need for professional boundaries with staff.
- Supports individuals to have a primary role in the development and implementation of their own IAPs
- Upon the request of the individual supported, the Peer Coordinator offers support and advocacy in treatment settings such as at IAP meetings
- Acts as an advocate as needed
- Shares information about community resources, including other peer-run groups, housing and benefit resources, and community events
- Accompanies and facilitates CBFS participants' engagement in community

activities and resources as requested by the individual being supported.
- o Occasionally provides practical supports including aid with transportation and other tasks as needed as requested by the individual being supported

Collateral Responsibilities
- o The Peer Staff remains up-to-date on current resources and knowledge of the recovery movement by attending trainings and reading related articles and/or books as available
- o Works with the RLC and other Recovery resources in the community to reinforce relationships with the CBFS Program and participants.
- Maintains information confidential within the team
- Completes administrative tasks as required including timesheets, basic documentation, etc.
- Responds to requests for information and phone calls in a timely fashion
- Notifies supervisory staff immediately in the event of a participant crisis or any behavior constituting an incident in the program. Follows established protocols for responding to crisis situations
- Other duties as assigned by a supervisor

Success Factors
- Adheres to program procedures manual
- Participates in required trainings and meetings as directed by Supervisor
- Participates in team approach
- Works within the process and procedures of referral sources
- Seeks and uses supervisory staff for training and supervision

Qualifications
- Lived experience with a mental health psychiatric diagnosis, extreme states and/or trauma required
- Experience in advocacy or peer support required
- Peer Support Specialist Certification strongly preferred and required with 6 months of hire.
- High school diploma required
- Ability to pass Red Cross, CPR and First Aid certification
- Valid Driver's License; reliable transportation
- Bachelor's degree from an accredited educational institution preferred

Abilities and Attributes
- Access to reliable transportation (with access to your own vehicle preferred)
- Bilingual/bicultural in English and American Sign Language or Spanish preferred
- Ability to act as an advocate and empower individuals to take leadership in their own recovery
- Ability and willingness to share own recovery story in an open and skillful manner
- Safe and approachable, including when under pressure

- Respectful of and compassionate toward other people's thoughts, behaviors, ideas and needs
- Self-aware and able to take responsibility for own mistakes, successes, weaknesses and strengths, as well as being able and willing to seek support when needed
- Optimistic and confident in approach and outlook
- Curious about and open to all perspectives, with a focus toward keeping up-to-date with information about peer support and developments in the recovery movement.

Job Title: **Advocate**

Job Summary:

The Advocate will provide trauma-sensitive peer support that is directed by the Defining Values and mission of the Western Mass Recovery Learning Community. The Advocate may be based primarily at one center or in the community and specific duties will vary.

Supervisory Relationships:

The Advocate will be supervised directly by a County Coordinator, Peer Community Coordinator, or Director

Principle Duties and Responsibilities

Role Modeling & Leadership:
o   The Advocate will share his/her own recovery story in intentional ways for the purpose of connection building, resource sharing, education, etc.
o   The Advocate will model coping, self-help and self-advocacy techniques based on their own training and experience
o   The Advocate will represent the RLC community in a positive light
o   The Advocate will promote shared decision making and ownership of the RLC's growth and values throughout the community

Advocacy
o   Upon the request of the individual supported, the Advocate will offer support and advocacy in treatment or other community settings
o   The Advocate will empower the individual supported in any complaint filing processes and will act as an advocate as needed

Information Sharing
o   The Advocate will share information about all community resources, including other peer-run groups, housing and benefit resources, and community events
o   The Advocate will remain up-to-date on current resources and knowledge of the recovery movement by attending trainings and reading related articles and/or books as available

Collaboration
o   The Advocate will be available to provide consultation and/or training to individuals in the community or working in traditional treatment settings as assigned
o   The Advocate will share information about the RLC with other community organizations and provide outreach as assigned

Team Participation
o   The Advocate will participate in all bi-monthly RLC team meetings and other necessary meetings as scheduled
o   The Advocate will participate in the on-line RLC Comm Log, including reading Comm Log messages at least once per shift

o   The Advocate will read the monthly RLC newsletter and be familiar with activities and events offered in different areas

o   The Advocate will attend a selection of RLC events, workshops and activities each year outside of their primary work area in order to support fellow RLC teammates and familiarize themselves with the 'bigger picture' of what the RLC is and does

Support

o   The Advocate will prioritize creating and supporting a trauma-sensitive, welcoming atmosphere

o   The Advocate will prioritize openness and helpfulness and will avoid saying, "I don't know," without following up or offering opportunities to brainstorm together

o   The Advocate will provide support to the individual as needed to connect with other supports in their community, including – in some cases – visiting other resources with the individual to help them get acquainted

o   The Advocate may provide practical supports including aid with transportation and other tasks as needed and assigned

General

o   The Advocate will value the individual's right to privacy and keep information confidential within the team

o   The Advocate will complete administrative tasks as required including timesheets, basic documentation, etc.

o   The Advocate will seek supervisory support when needed, including using the on-call protocol as appropriate

o   The Advocate will be responsible for responding to requests for information and phone calls in a timely fashion

o   Other duties as assigned by a supervisor

Minimum Qualifications:

Education and/or Experience:

o   Lived experience with a psychiatric diagnosis, extreme states and/or trauma required

o   Some experience in advocacy or peer support preferred

Abilities:

o   Access to reliable transportation (with access to your own vehicle preferred)

o   Bilingual/bicultural in English and American Sign Language or Spanish a big plus

o   Ability to act as an advocate and empower individuals to take leadership in their own recovery

o   Ability and willingness to share own recovery story in an open and skillful manner

Attributes:

o   Safe and approachable, including when under pressure

o   Respectful of and compassionate toward other people's thoughts, behaviors, ideas and needs

o   Self-aware and able to take responsibility for own mistakes, successes, weaknesses and strengths, as well as being able and willing to seek support when needed

o   Optimistic and confident in approach and outlook

o   Curious about and open to all perspectives, with a focus toward keeping up-to-date with information about peer support and developments in the recovery movement.

Recruitment

Once you've readied your organization as best as possible and a job description is developed, the agency is ready to hire a peer-support worker. The next phase is to advertise the position and then select candidates who meet the minimum qualifications for the job. Recruiting qualified employees is an important aspect of hiring a peer-support worker just as it is for any position in the agency.

The nature of the peer role requires that you give careful consideration to the ways to sensitively approach candidates' experience of their lived experience of emotional distress and recovery, as well as to how to assess job readiness. Recruitment efforts need to be consistent with the requirements of the Americans with Disabilities Act (ADA), but also gather relevant information needed to make a good hiring decision. The ADA, a law to ensure that people with disabilities are not subjected to discrimination, places certain requirements on employers in their advertising and hiring practices.

In advertising, an employer can't use any language that would discourage people with disabilities from applying from the job. However, the law explicitly states that someone *without* a disability cannot claim discrimination because they *don't* have a disability. (ADA, Subpart IV, Section 12201(g) Claims of no disability**.** Nothing in this chapter shall provide the basis for a claim by an individual without a disability that the individual was subject to discrimination because of the individual's lack of disability.) Hence, there is no preclusion from advertising the requirement that applicants have lived experience as this qualification is related to the essential functions of the job.

It's best to be explicit, with statements such as "lived experience of a psychiatric diagnosis" or "a history of extreme emotional distress, substance abuse and/or trauma," and/or "history of experience with psychiatric hospitalization and/or receiving other mental health services," etc. to weed out applicants who will not understand the general term "lived experience." (Be prepared for many applicants to still be confused, even if you are explicit as this is such a shift from the norm.)

A few ad examples:

Certified Peer Specialist, 20 hours per week. Offer peer-to-peer support and advocacy to individuals receiving services, facilitate support groups, and participate in organizational planning committees. Requirements: Personal experience receiving mental health services and/or psychiatric hospitalization; Willingness to share personal experience to educate/inspire others; Certified Peer Specialist (or willing to be trained and take certification exam within first six months). Preferred: Past peer support and group facilitation experience

Peer worker, 40 hours per week. Split your time between a group residence and a day program setting offering peer support and group facilitation. Provide leadership to advisory board of individuals receiving services. Facilitate regular Wellness Recovery Action Planning classes. Job requirements: Lived experience with your own psychiatric diagnosis, extreme emotional states and/or trauma; Training as a WRAP facilitator (or willingness to be trained within first six months of employment. Preferred: Access to a vehicle you can use for work; Hearing Voices Group facilitation training.

Community bridger, 30 hours per week. Support people transitioning home out of hospital settings. Support them to connect with community groups, address housing/benefit needs, etc. Advocate with them at discharge meetings as requested. Required: Personal history having been given a psychiatric diagnosis and/or as a trauma survivor; Advocacy-related training or experience. Preferred: Certified Peer Specialist training.

What about where to post your ad? Especially if peer roles are new to your area, it can be tough to figure that out. However, here are just a small handful of ideas:

- Contact places like the National Empowerment Center and the Mental Health Consumers' Self-Help Clearinghouse. These national organizations will sometimes be able to help distribute your ad (or give you an idea of where to post it)
- Does your state have a statewide peer-to-peer organization? If so, this is another great potential resource for getting your ad out there. (Here's a great listing of where these organizations are located: http://www.mhselfhelp.org/statewide-organizing/)
- Craig's List
- Your local career center (check here for the one nearest you: http://www.careeronestop.org/)
- Facebook. Yes, Facebook! You can even pay for a (relatively inexpensive ad) and target it geographically to your area.

The Interview

Planning an open and well thought out interview process should help ensure you appoint the best possible candidate for your new peer role. As with any recruitment, the aim is to satisfy as best you can the required competencies and values for the role.

The ADA strictly precludes questions about a the nature and severity of an applicants' experiences with psychiatric diagnosis and/or treatment, but does allow questions about the candidates' ability to meet the essential functions of the role. (Under the law, employers generally cannot ask disability-related questions or require medical examinations until after an applicant has been given a conditional job offer. This is because, in the past, this information was frequently used to exclude applicants with disabilities before their ability to perform a job was evaluated; An employer cannot make any pre-employment inquiry about a disability or the nature or severity of a disability. An employer may, however, ask questions about the ability to perform specific job functions and may, with certain limitations, ask an individual with a disability to describe or demonstrate how s/he would perform these functions. EEOC. http://www.eeoc.gov/laws/statutes/ada.cfm.)

Essentially, you want to determine the ways that a person is prepared to fulfill a job where their lived experience needs to be skillfully utilized, rather than things such as diagnosis(es), hospitalizations, treatment history, etc. Below (and on the following page) are some interview questions that do not violate the ADA requirements and get to the essential functions of a peer support position.

1. Can you tell me some ways that you might use your personal lived experience to support the people you'd be working with? (*Answer should include ideas around "inspiring hope," and around connecting with people from the place of shared experience AND the tools or strategies that the person used to move to a better place.*)

2. What role has peer support had in your own recovery? (*If the person is not familiar with or has not utilized peer support, they are probably not a good candidate.*)

3. This job requires a willingness to share some pieces of your personal story when it makes sense to do so during your work. When could you see sharing your story as a part of your work here? (*Answer may include ideas around 1:1 interactions, at staff meetings or trainings when acting a change agent, etc*.)

4. *Do you have any life experiences that would make you valuable to this program?*

5. *What have you learned through your own use of services that you think would be useful to your work here?*

Below are some examples of questions you might ask to better understand the interviewees overall skillfulness in areas related to peer work:

1. How would you define the 'peer' role and how would you describe its key role or tasks. (*Should include mutuality, sharing mutual experience, non-expert role, supporting people to become self-determining; inspire hope, being a change agent, being an advocate, etc. Should NOT be about "making people better," "counseling people" etc.*

2. Part of the role of a peer support worker is to model recovery by sharing some of your own personal experiences. Would you be comfortable doing so?

3. What do you know about the concept of "recovery?" What is your personal knowledge of this and how did you come to this understanding? (*Answer should include mental health-related recovery or healing, not just 12-step substance abuse recovery. Concept described should include values of potential for everyone to recover or move forward in life.*)

4. If you were working with someone who has become resigned to the idea that his or her life will always be limited because of a psychiatric diagnosis or other challenges, how would you try to support that person? (*Answer should include sharing personal experiences, sharing mutual feelings, sharing tools and NOT telling the person that, of course, it will get better or giving them advice, "well, if you'd do ....you'd have a better chance…"*)

5. In many ways, the peer position is a pioneering role. What skills will you bring to the job that will allow you to advocate for people while being in partnership with other staff members? (*Answer should include using personal story to demonstrate the experience from the perspective of using services; should also include something about respectful communication to everyone; and an excellent response would include something about negotiating power and conflict*)

6. Peer Specialists are often considered to be "change agents" within organizations. How will your experiences help you to be a change agent and how would you see this happening (*Anything about being able to share experiences with staff to give them more understanding of the experience from the perspective of someone who's 'been there'; sharing alternative approaches from the self-help community that augments the work of clinicians (like WRAP), etc. If this notion is a shock to the applicant, probably not a good match. They very well may see the role as a mini-clinician and will detract from the value of the role.*)

7. Some staff here may be apprehensive about or unsupportive of peer support. How would you deal with this

8. If you were in a situation where you were called to help deescalate a situation, how would you respond in that situation?

Below are some questions you might ask to help you get a sense of someone's overall ability to be in the setting(s) involved, their dependability, etc.

1. This position will require you to work in _____(identify settings, like inpatient, emergency room, day treatment setting, residential setting, a setting where restraints are sometimes used, etc.). How will your personal lived experience support your work in this/these settings? (*Answer should include peer strategies, even if the person's own experience didn't include the particular setting. At the other side, if someone says that their experience was very painful, that they can't think of any strategies because they don't believe in that kind of treatment, or say anything to indicate that they would be uncomfortable in the setting, it would probably be a bad match.*)

2. While working here you may be a part of some situations that disturb you or make you uncomfortable. How do you think you would handle these situations, both when they occur and after the situation has ended?

3. If you felt your job was causing an increase in your stress level, what would you do? (*Answer should include seeking supervision and NOT include anything about going to other staff in a "patient" kind of way.*)

4. Can you tell me about your history of dependability in prior positions (or, if no recent positions), in other activities in your life.   (*You CAN ask this. You CAN NOT ask history of hospitalizations, history of taking medical leave, or when someone was "last sick."*)

5. Do you function better with the independence to create your own work structure, or work better with a clear structure?

6. Some people are here because they have been found not criminally responsible for serious crimes. Those crimes range from theft and arson to rape and murder. Some may have been high profile and you may have read or heard some pretty outrageous things about them in the media. What are your thoughts and feelings on working with people in this situation?

7. Can you tell me about a time you experienced a conflict with a co-worker? How did you handle it? (*Or, alternately, ask about a time they experienced a conflict with a supervisor. Do not just ask this in a 'yes' or 'no' format, as it becomes much less likely to elicit useful information.*)

It can also be very useful to ask questions about:

- Understanding the relationship between trauma and mental health
- Understanding of trauma-informed practice
- Understanding of the history of the 'peer' role *(It can be very helpful for someone to have a sense of this role not being 'new' and coming from a rich history)*
- Familiarity with various community resources
- Familiarity with local and statewide peer-to-peer organizations *(often, those who do the best 'peer' work will come with an investment in staying connected to others in similar jobs)*

Additionally, asking people well-designed scenarios can also be powerful. Scenario questions are at their best when the interviewer is seeking to learn not just what someone knows, but also what they might need to unlearn. For example:

> You've been working with Maria for about a month. She told you that she hasn't been keeping up with her bills and is afraid her lights will be turned off soon. She hands you unopened bills and also says something about having heard about a discount program for individuals on fixed income. She is hoping you'll sort through the bills, get them paid and look into signing her up for the discount program. What do you do?

In this scenario, you're looking not just for some good ideas of how to respond, but also a sense that the interviewee is prepared not to simply jump into the 'fixer' role that is so familiar to so many of us. Another example:

Like many other people who choose to work in the "helping" professions, peer specialists often come to these jobs because of the personal gratification gained from the work. HOWEVER, the role of work in the person's own recovery and wellness should NOT be part of the hiring process, any more than it would be for any other position. In other words, you should not be hiring someone because you like them and believe it would be good for *their* recovery to be working in the role. This is just one of several pitfalls that employers tend to fall into during the hiring process. Others follow below.

- Shifting someone who has been in a clinical role with your organization for a long time into a peer role because it's easier than hiring and they are already familiar with the organization (Occasionally, if the employee's orientation was already toward being a change agent and sharing their personal experience, this can work out. However, more often than not, it leads to a situation where the person essentially just keeps doing what they were already doing under a new job title.)

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- Consciously (or unconsciously) lowering hiring standards. (During the interview process, it's a good idea to ask yourself this question: "Would I think it were absurd to consider this person for other roles in this organization?" If the answer is yes, you may be lowering your standards for hiring into this role which will ultimately not benefit anyone, and fails to value the peer role as one that truly requires a talented and committed person to do it justice.)
- Hiring one of the first people who apply, because you haven't gotten many applications. (It's far, far easier and less painful to let a job go unfilled for a little while then it is to fill it with someone who ends up not being a good match. It may take a little while before you figure out the best places to post your ad, and/or before people in your area catch on to what the job is and start applying. That's okay. It'll be worth the wait.)

Remember, the proficiencies of someone working in a peer role should include:

- Believes that everyone can progress, heal and move forward in life.
- Values choice and self-determination.
- Can describe the peer role in relation to both people using services and those providing services.
- Values the peer role as a new non-clinical position to augment and not duplicate traditional services.
- Recognizes the relationship of the peer role to the peer and self-help movement.
- Has the ability to "stand up" for people being served, but with respectful and effective communication.
- Recognizes the importance of "hope" in healing.
- Has the ability to describe a healing process through the use of personal story.
- Has the ability to use personal story to describe strategies toward healing.
- Can describe elements of a recovery-oriented mental health approach/can describe things within the mental health system that hinder the recovery process.

Having interviewers who have a good awareness of recovery and the peer role, especially people with lived experience, and particularly those who are or have been peer workers, will lead to hiring candidates who will best serve the needs of the role and, ultimately, people using services as well as the organization itself.

One last note: When committing to hiring peer roles into your organization, it is important to commit to the values that underlie the role in a comprehensive way. This includes:

- Constructing an interview committee for peer (and ideally all) roles in your organization that includes people in a number of positions, including those who are receiving services.
- Using language (to the best of your ability and understanding) in job ads, job descriptions and job interviews that is respectful of individuals that have experienced trauma, psychiatric diagnosis, etc.
- Being flexible, but holding to reasonable expectations for timeliness, interview responses, job applications, resumes and cover letters *(Having low expectations at any stage of the process doesn't do anyone any favors!)*

Setting Pay Rates

Pay rates are all over the map where peer roles are concerned. Often, saving money is listed as a benefit of implementing peer roles. It's true. There is a great benefit to the community—both from a financial and human perspective– in supporting people to stay out of the hospital, to get unstuck and move toward fuller lives, and so on. However, many believe it's a mistake to try and find those savings directly in employee salaries.

In some settings, individuals in 'peer' roles are making the lowest wages in the organization. This is often a sign that the organization has misunderstood the purpose and value of the role. It is not unlikely that at least some organizations who fall into this group have bought into the myth that peer work is about the individual peer worker's personal rehabilitation rather than about what they can give to the organization. It's also possible that the organization has the best of intentions and understanding of the role, but just didn't have adequate funds to support it. Either way, it's not a great place to start from as it automatically communicates to the person working in the role (and those around them) that they aren't as valuable.

Perhaps most commonly, organizations set wages for peer roles at exactly the same rate as other entry level direct support workers. This at least communicates that there is an effort toward equality being made. However, it begs the question of whether or not—on average– peer roles constitute 'entry level' work.

Although rarer, some organizations set wages at a rate substantially higher than entry level work. While this can be a challenge for a number of reasons including budgetary limitations and process requirements in agencies that are unionized, it is worth serious thought as it communicates a strong message about value and commitment to the role. In the end, we can't tell you exactly what is the right rate to pay peer workers, but here's some additional food for thought:

- It's hard to change your rate structure once you get started, so it's important to start at a rate that is truly well thought out
- The pool of people who have had substantial personal experience (with trauma, psychiatric diagnosis, the mental health system, etc.) who are *also* willing to openly identify in that way

and share that experience who ***also*** really understand and are good at this work and who ***also*** want to be doing it isn't that big of a group… Finding someone who meets all the criteria listed here is fairly rare, and when you find them, they're going to be worth hanging on to. That will mean paying a good wage and/or providing advancement opportunities.

- There are many types of 'peer' roles, some of them requiring more sophistication than others. However, on the whole, these jobs require a substantial amount of skill development and confidence and most positions should not be seen as entry-level or on par with other entry-level direct support work. Setting a pay rate that is entry level sends a confusing message that contradicts the demands of the job.

- Multiple organizations that have had success at recruiting talented people to work in peer roles that are widely respected and impactful name establishing a reasonable pay structure as a contributing factor to positive outcomes.

There is, of course, one complicating factor and that is for people who are wanting to work part-time because they are receiving Social Security Disability Income (SSDI) and/or Supplemental Security Income (SSI). This can get particularly challenging when someone is just testing out the waters of the work world and doesn't want to risk losing their benefits, or is reaching the point where they want more hours but there aren't quite enough hours available to help them make the leap from work plus benefits to just work. The rules for working while receiving SSI verses SSDI are quite different, as are the options for people who are working toward a transition. At times, the challenges involved may even lead an employee to be put off by a higher pay rate. If your organization isn't already familiar with the ins and outs of supporting employees who receive SSDI and/or SSI, this is a good time to get informed. This is especially true since there is so much misinformation or lack of information about some of the supports that are available. Although clear and easy-to-understand training and information on this topic can be hard to come by, the One Stop Career Centers are often a good source either for information or ideas about where to find it. (www.careeronestop.org)

Whatever you decide to do, it's a good idea to ask around about pay rates for peer roles in other organizations and to really think through not just what will help you get started, but what feels like a good place to land over the long term.

Supervision

There is absolutely no question that the most qualified supervisor for someone working in a peer role is someone else who has also worked in a peer role. This is because:

- People who have 'been there' themselves are better able to understand the challenges of working in a system where one has previously received services.
- People who have worked in peer roles are better able to understand the tensions and potential isolation of working in a role where they may be one of the only people in that position and are nonetheless asked to challenge others and act as a change agent.
- People who have been through the trainings for peer roles are more likely to understand the core competencies and functions of the job.
- People who have been asked to sign on to the same code of ethics and/or values are more likely to understand the integrity of the role and when certain duties may be in conflict with it.

Another bonus of having a supervisor with this experience is that they are often in a much better position to unite people working in peer roles across an organization. That is to say, in organizations where individuals working in peer roles are placed separately on various clinical teams, they are much less likely to know one another and much more likely to feel isolated in their work. On the other hand, when there is a centralized supervisor who has also worked in a peer role and who is responsible for supervising others in peer roles, there are more likely to be regular team gatherings for all individuals in peer roles and for individuals to feel that their roles are well understood and supported.

In organizations where this just isn't possible, some ideas include:

- Requesting training on peer roles from local or national peer-to-peer organizations
- Seeking supplemental supervision for your employee from a local peer-to-peer organization
- Sub-contracting with a local organization to hire people to work in peer roles in your agency and so that their direct supervisor is someone who has that experience
- Being generous in offering paid time to your employees working in peer roles to attend net-working meetings, trainings and other gatherings related to peer roles offered by other or-ganizations

The Transformation Center—a peer-to-peer organization in Massachusetts– also offers a booklet specifically for individuals who have never worked in peer roles but are now supervising them ("*Supervision: Meeting the Needs of CPS's in a System in Flux*") that some may find useful. It can be found on-line here: http://transformation-center.org/account/cps-supervisor-training-home/cps-supervisor-training-material/.

Performance Reviews

Performance reviews, both formal and informal, are an important part of any employee's ongoing success and satisfaction in their work setting. Performance reviews allow the opportunity to ensure that all parties are viewing the employee's work on the same page. Strengths and areas that need improvement can easily be identified and clarified early, letting the employee demonstrate growth based on the feedback or, alternatively, make it clear that the job is not a good match.

Employers are often tempted to create "special" policies for people in peer roles. It can be difficult for both the employer and the employee to fully switch hats from provider/service user to employer/employee. However, in the end, these special policies don't benefit the peer worker or people using services. They frequently create dissention and resentments on the part of other staff and communicate the very message that the peer role is supposed to combat: 'you can't expect *those sick people* to work at the same level.'

Peer workers can and should be expected to meet their job requirements. A well-crafted job description and supervision that includes performance reviews are vital tools to support peer workers meet their obligations. Having the functions and tasks clearly delineated makes it possible to identify how peoples' work is measuring up on each item.

As an employer and/or supervisor, you always want to give an employee the opportunity to move from where they're at to where you need them to be. This is no different for peer workers. They should be offered possible reasonable accommodations if you see a way these might be helpful. A Plan of Action of some type should be put in place for areas that need improvement. But there should be a specific time frame attached to the plan, and if the person is still unable to meet the requirements, the person should be terminated or transferred to another job for which the person is better suited.

An Interview Across Roles

There's little that's more telling than a conversation with people who've 'been there.' In this instance, when we say 'been there,' we mean people at an organization who have gone through the process of implementing peer roles and have witnessed or been a part of their impact.

Below you will find an interview with a clinician, a peer worker and the Director of Recovery based on Advocates, Inc in Framingham, Massachusetts. It is meant to give you an opportunity to learn about one organization's successes and challenges with peer roles from multiple employee vantage points.

Who are you and what is your role with Advocates?

Peer Worker: Michelle Love, Peer Support Coordinator, 6 1/2 years

Director of Recovery: Keith Scott, Director of Recovery & Peer Support, 6 1/2 years (25 years with the organization)

Clinician: Amy Morgan, Assistant Director of Psychiatric Rehabilitation Services, 23 years

When were peer roles first implemented at Advocates?

Keith: It [was] about 25 or 26 years, although not because of me. I was hired for my "lived experience", but to be open about that while I still performed all of the responsibilities of a traditional staff person. About the same time, however, the agency did hire someone who had received services with us to function in a strictly "peer" role.

I think most people in the organization did not see that role as a real position, with significant value, and saw it, instead, as a way to help one person have an opportunity to make some money in a low stress job surrounded by mental health professionals who could help support them [with the belief] they [would] invariably became symptomatic again. It was well intentioned, but misguided, I think.

Ultimately, that did not work as the person, without the proper support or connection to other people doing similar work, eventually was overwhelmed and left, and then we went another fifteen years before we tried again.

What did the organization do during those fifteen years to build up their readiness?

Keith: We did [an] enormous (ten years) [amount] of ground work with Pat Deegan and others to lay the foundation for that renewed effort. Like creating a set of performance standards oriented around the idea of "recovery."

Amy: [Also], we have exposed our staff and the people we support to a wide range of presenters, speakers, consultants, films, workshops, conferences, etc. For nearly 10 years all of our trainings have been open to people to whom we provide services not just "staff". We also started a group called Promoting a Culture of Respect where people working in any role in the organization could feel supported and safe about their own lived experience, even if they were not in a designated "peer" role.

An Interview Continued…

When you were getting ready to try peer roles again, what did that process look like?

Amy: My recollection is that there were lots of discussions where feedback was sought about how does an organization do this and do this well. There was a great deal of thought put into the design of the hierarchy and a clear decision was made that we needed to have a senior level person with lived experience supervise such a team so that people in the role of Peer Specialist would not be marginalized, scapegoated or co-opted into other roles.

Keith: Yes, the decision was made to place the person (me) on the Senior Management Team and give me authority (with a colleague responsible for clinical oversight) to lead the Mental Health Division in a direction that would focus, at least in part, on "recovery" and "peer support" and the kinds of changes necessary in the Division to help people move forward with their lives – self-determination being paramount among them.

It can be difficult to be in a more traditional role and then move into a 'peer' role in the same organization. How did that work for you, Keith?

Keith: I think it has worked because I was originally hired back in 1989 for my "lived experience." I was hired to be open about my life in the mental health system with the people I was supporting in a group home. That part was explicit until I began to be promoted and moved into more supervisory, "clinical" and administrative roles within the organization. Over time, fewer and fewer people saw me as someone with a diagnosis and psychiatric history as almost all of the people that I started with had left the agency. There was some advantage in that for me and I began to "pass as normal" for a number of years, until this opportunity was created. The other reason I think it has worked is that a couple of very senior people in the organization have always known about my experience and have supported me through hospitalizations periodically throughout my work here. I have enormous support here, right up to the CEO.

Now that you've had peer roles in the organization steadily for the last 6 1/2 years, how are they seen by others?

Keith: For the most part, peer roles here are embraced and highly valued. The [peer] team members are sought out constantly by senior people to sit on committees and speak to stakeholders and the Board and offer their experience to help inform decision making.

Amy: I cannot imagine our organization without the Peer Specialist team. They are an integral part of the way we offer and provide services. There are people we support who might not be as satisfied in life as they currently are, if we had only been [able to] offer them the traditional clinical services that we had before.

Is the organization still working to grow and expand its perspectives?

Most recently our organization has invested a great deal of time and money in to training in the Finnish Open Dialogue approach due to the recovery outcomes related to this way of working in Western Lapland. Our Medical Director runs a "medication optimization" program and people seek him out for psychiatry services explicitly to reduce or come off psychiatric drugs. We have also conducted surveys such as the REE to measure our success at offering recovery enhancing environments.

An Interview Continued

Michelle, having worked in a varied peer roles in this organization, do you feel that your role is well respected and understood?

Michelle: [Overall], I am treated as a valuable member of the organization. I do feel respected and valued. [However], at times when risk or crisis is taking place I feel minimized in my role and rejected as offering any valuable feedback or advice. I feel that there are a good amount of people who understand the role, but there are still a large amount of the Mental Health division that is not familiar with the role.

How has Advocates organized peer roles so that they are supported and can be sustained, even if its all still a work in progress?

Michelle: By having our team as a separate entity working together, instead of separately [with peer roles assigned out to teams on their own], creates the ability to provide support to others, handle conflict and manage the difficulties of the job. I think that [having the opportunity to work] in a variety of areas within the agency's Mental health division instead of one specific area [has also helped]. I think our life experience has been useful in these areas, [too].

Keith: We have held as closely as we can to a code of ethics that is clear about our responsibilities, the most salient of which is the commitment to support the principle of self-determination in all matters. I have had enormous support from the executive leadership of the organization to operate this way and I think it has [also] contributed to us being to develop the kind of relationships that are most helpful to the people with whom we work.

Amy: I do not think we would have had the success we've had without a Director [Keith] who is a person with lived experience. [Keith's] role is to constantly hold true to the principles of peer support. Time and time again, the role of peer support person could be co-opted into a pseudo-mental health worker kind of role. However, with the leadership and decision making power inherent in a senior staff person's role, this has not happened.

Michelle: The structure of our Peer Specialist team is extremely important but it is also important that [Keith] is a part of the leaders of the organization. Having more acceptance from those above helps to gain acceptance from the rest of the division. I think that we are also a part of a lot of committees, senior level meeting and quality management meetings. This allows for a better spread of our role and a clear understanding of what we do.

Can any of you speak to some of the chalelnges of integrating peer roles?

The challenges vary but the theme tends to be the same. Often our way of working with people is misunderstood and staff feel we are agents of persuasion rather than agents of change. For example, we do not read peoples histories. We meet people and if this is something they want to share with us they are welcome to but we do not obtain information about or share information about people we support without their consent. Explaining this to staff has been difficult and [instead] we are asked to provide information about how someone is doing or we are used as a backup for finding the truthfulness of information someone has given.

An Interview Continued

Keith: Trying to create "culture change" here [has been the hardest]. Particularly around the idea of "risk" vs. autonomy. Trying to help shift the conventional wisdom of traditional mental health to recognize and be open to the idea that simply having a psychiatric label and struggling with whatever experience you are having does not mean that you should have to surrender or have taken from you any of your rights as an autonomous human being. Having those discussions with colleagues I have known for half of my life has been hard, particularly when they don't agree with me.

Amy: Our organization has hired people into peer support worker roles who have or had received our services. This has proven to be both successful and unsuccessful. When it does not go well, it's very hard due to the various conflicts in roles, i.e. support provider and employer.

How has your organization benefited from integrating peer roles?

Amy: The benefits are too many to list! Community integration; hope; social connectedness; improved medical care; elimination of forced treatment; the belief in one's own self and one's own voice; self-advocacy; activism; employment; positive changes in family relationships; shared understanding ; decrease or elimination of use of psychiatric drugs.

Any closing thoughts or recommendations for organizations that are just getting ready to implement peer roles?

Keith: Create a position on your leadership team, a position with real authority and support at the highest level, to oversee the implementation. Create an infrastructure so there are opportunities for people working in peer support roles to grow professionally. Be clear about the nature of the roles. Commit to the special nature of those roles and the relationships that they can create if they are not charged with "clinical" responsibilities like medication administration or clinical documentation or managing someone's money. Have everyone in these roles connected to one another as part of a team and have them supervised by others with experience doing that same work, rather than by clinical staff. Pay them well and make sure they get to trainings and conferences where they learn the skills specific to their unique roles and connect with others doing the same work in other settings and for other providers.

About Advocates: Advocates employs over 1000 staff members and serves 20,000 individuals at over 100 sites across Eastern and Central Massachusetts. Although the discussion above pertains primarily to their mental health residential and crisis services, the organization offers a full array of supports including:

Residential Supports
Outpatient Mental Health
Outpatient Addiction
Psychiatric Emergency Services
Home-Based Services for Children and Families
Community Justice
Advocacy, Benefits and Legal Services
Family Supports
Employment and Vocational Services
Day Habilitation

For more information, visit their website at www.advocatesinc.org.

A Word From YOUR Peers!

In preparation for writing this book, we sent out a survey to people in provider roles, peer roles and people receiving services to ask them their thoughts on peer roles. Over 200 people responded, including 60 providers. Here is some of what your peers, those 60 providers ((a mix of social workers, mental health counselors, direct care workers, and administrators), had to say:

<u>Have you had any positive experiences with the integration of peer roles in your organization?</u>

"Of course - countless. So glad to see that by now it is a no brainer for all staff that we have to have peer specialists on the team and we all want more than we can currently afford. The way people we serve are now present in meetings (when they physically might not be - which we hope to avoid) is so much better. The person in the center and driving it all is more and more taken as the norm rather than the exception."

"The people I support who utilize peer support love it. I have had mostly positive experiences with peer supports, enjoying listening to their stories and watching them connect to the people I work with in a way I cannot, giving them something I cannot - and I greatly appreciate this, that they are offering another support and resource to help them help themselves."

"Peer workers help our organization maintain balance and wholeness."

"All of my experiences with implementing peer roles in my organization have been positive for the people we support and the staff. The people we support now have access to a whole new wealth of support. The relationships that the people we support build with the peer specialists are ones that directly complement the staff in clinical roles. As a peer specialist who is more involved and spends more time just being with the people we support they get to know the person who receives services on a deeper level."

"Yes, I have had many. From my view of the organization i have most valued the cultural changes the Peer Specialist team has help bring about- increased focus on human rights, person centered care and alternative, non- traditional care."

"Yes, absolutely! We are still very much in the learning stage about integrating peers into professional teams, but thankfully everyone has been eager to participate in the learning. Having peers on staff definitely makes us much more cognizant of the probability that full recovery can occur, and spurs us all to attend to our interactions with clients so as to make each and every interaction recovery focused."

"I have to admit that I was one of the skeptics when we first started down this path. However, I've become a true 'believer.' As with any position in our organization, there's been some mishaps, but there's been far more good than bad and for some we serve, it has seemed to be life changing."

What has been the biggest challenge/negative impact of adding peer roles at our organization?

"Money. Can't afford enough."

"Sometimes staff view the role of the peer specialist to be a threat to their authority and as a result become defensive when a peer specialist makes suggestions or asks questions. The peer specialists work very hard to conduct themselves in a way that is non-confrontational and supportive of the greater mission."

"People don't like change and they behave in all kinds of ways to avoid it and return to the status quo. In our organization this manifests itself in traditional staff getting very active that we have gone too far and are creating unsafe, risky environments."

"The biggest challenge is for the staff and clients to not view the peer specialist as another professional support person. It seems to be as difficult for clients to understand the role of their peer support as is it for the staff on the provider team. Some of our peer specialists have had some difficulty with this too. Most of our peer specialists have received services from case managers, and it sometimes seems tempting for them to fall into the role of assessing, and thinking of themselves as being in the "expert" role. It's tempting for the people they serve to want them to fall into that role as well. We all have to work at keeping the new vision in the forefront - otherwise it's easy to just do what we've always done."

"It's really hard to navigate funder requirements like documentation with a profession that I'm told isn't supposed to routinely document. I'm still trying to figure out how to negotiate al the needs on all the sides."

"I notice that even people who have lived experience don't really seem to fully understand the peer role and what it is supposed to look like. Everyone seems to still be figuring that out. It's just so different. It's going to take a while."

What training have you had that has been helpful to you as a provider/supervisor of peer roles?

"Intentional care training "

"we were very blessed to have many years of consultation from Pat Deegan as well as a variety of training opportunities both in house and through other venues. the ground work laid by Pat Deegan was the most helpful."

"I haven't had specific training, but have a familiarity with Sherry Mead's intentional peer support model through my own research. That was helpful for me."

"We have had no formal training in implementing peer roles, and no guidance from our DHHS staff. However, 10 years ago we implemented a client-directed approach to all of our services which has included the use of client feedback measures which provides us with real-time feedback on progress towards goals in our services as well as the quality of the helping relationship. This helped us become recovery-focused, when previously we had been largely maintenance-focused, and also helped us become more aware of the importance of transparency and collaboration in our interactions with the people we provide services to. Our recovery focus naturally pointed the way to the involvement of peer supports."

"Talking with and visiting other providers who were ahead of our organization was a big help."

"Part of the problem with this role is that there isn't a lot of 'training' out there for providers/ supervisors. Often, we're asked to implement the role because the funder said so, but we're not given a lot of support to understand it. So, we're making up our training as we go along and consulting with our local and statewide peer-to-peer organizations as often as possible."

"I've made a point to go to some of the big conferences (e.g., Alternatives) to check out what others are doing. The only problem is that there's such an array of presentations, that it's hard to tell which are really on track sometimes."

What training do you wish were available to providers/supervisors to help you through this process?

"Training on the challenges and the pitfalls of systems change as well as how to support the Peer team so you don't end up with disempowered tokens."

"Any training would be great. There are so many things to learn about the benefits and challenges of integrating peers into community mental health work. When things get hectic and difficult, it's easy for everyone to fall back on being directive to the people we work with, losing sight of what the person we're serving is experiencing and needing, instead of what we need in that moment, and to lose sight of the probability that everyone can recover.

"Implementation of peer support training should, of course, be led by peers, but I think it would also be helpful to include administrators and clinical managers/supervisors as trainers because there is an impact on the entire organization when peer supports are implemented, and everyone in all roles has a perspective on what can make it go as smoothly and effectively as possible.."

"I wish there were a readily available, in-person supervision training for providers who are in a position to be supervising peer roles."

"How about even a training that summarizes what people in peer roles are learning in their trainings? I feel like I'm sending someone to get trained in largely unknown information."

What do you find most confusing about peer roles?

"How different they are used (not in a good way - but often too much like clinical team members with main stream expectations)."

"I confess that having been a psychologist for almost 40 years, the specter of boundary issues and ethical lapses that could adversely affect the agency are the most confusing and worrisome to me. These issues are so prominent in the thinking of a clinical administrator that it's hard to figure out how to adapt my thinking to a staff role that does not operate within the same rigid set of rules about self-disclosure, amount of time spent with the people we serve, the "dual relationships" that are just a given within the world of peers, etc. I just try not to let my anxiety get in the way of making sure the vision of peer support gets lost :-)."

"It's just so hard to visualize what they're actually supposed to be doing. I hear more about what they're not supposed to be doing, than what they are. I still feel a little lost."

"I want to do a good job of implementing peer roles, but the financial piece is by far the most confusing. It's just not clear how we are supposed to implement these jobs well without additional funds, and with the same old traditional requirements as always."

What have you learned about peer roles that you really wish you knew from the start?

"How profoundly having peers in our organization would affect everyone. Some direct service staff feel threatened by their presence, some clients are not interested in talking with someone who has a shared experience (they think the peer specialists "don't know anything" because they don't have a lot of degrees after their name), how discounting that people in all roles in the organization can be about the value of lived experience and the possibility of recovery."

"How much it would change things for the better, and even make traditional jobs easier in some cases. When people feel more connected—even to just one person– sometimes they just come alive and start being interested in other support, too."

"How afraid and reactive some people would be. If I'd known that, I would have encouraged us to spend more time in preparation for introducing peer roles. We had a lot of turnover in the beginning primarily because people weren't being treated well at all."

"How long of a process it would be to really get everyone on board with not only being willing to post a job ad, but really understanding what that job was."

"How strong a peer worker can be in their work. A lot of us—myself included– had some pretty embedded assumptions about what a peer worker would look like. I've learned a ton from the peer workers in our organization, though… including that they can be just as smart, skillful and impactful in their work as anyone else."

"To have high expectations. We started out hiring, thinking that this was all about helping the peer worker get some job training. It's not. It's about supporting clients and the organization in a really meaningful way. We would have made totally different hiring decisions at the beginning if we'd understood that."

What specific advice would you give to other providers who are just starting this process?

"Talk to people/organizations/peers who have done this successfully - invite them in to spread the word to staff, so the benefits are clear (with living examples) from the start. Get peers well trained and make sure they have the right kind of supervision and support. Make sure to create a thoughtful job description and revise agency policies as needed."

"Pay a lot of attention to how easily this role can get marginalized."

"This process really needs to have a couple of strong champions within the leadership structure of the agency in order to help support the process through it's ups and downs."

"As a provider, the most important advice you need is to hire a director of peer support and recovery who has tremendous strength and a lot of experience; The director will need to learn to support a team through incredibly complicated issues that no one else in the clinical work environment has to deal with. As a peer specialist, you're job is twice as hard as a non-peer staff's job. Not only are the peer specialists facing the challenges of supporting people but also the challenges around working with clinical staff. Peer specialists have to be twice as savvy and twice as tough to make it, and the ones that I work with are."

"Having peer specialists is vital to ensure the people whom we provide services for are being treated with honor, dignity, and respect at all times - human rights. And they help to provide a common ground between staff and clientele."

"Go into it with as much knowledge and planning as you can. Talk with and/or visit other agencies that have experience with implementing peer services, and attend any trainings available. But, know that you will never be able to fully understand in advance how deeply the implementation of peer services will impact everyone involved on both a personal and professional level. Stuff will come up that you never could have predicted, and even though it might bring you to your knees at the moment, trust that it's all good in the end, because you'll be required to examine your values and your principles every time something new comes up."

And a few words from people working in peer roles to you:

"Be attentive. You don't need to talk a lot."

"Invest some time in educating your employees about peer roles before dumping us in to the environment. Don't expect all the education to be our responsibility. It's exhausting."

"There needs to be plentiful and repeated exposure to basic trauma informed care, from the front desk to the docs. I can and do expose folks here to those ideas by relating my own experiences and the things I learn at conferences and training, but there needs to be more time spent on it so as to embed the concept in practice. When trainers go away we often go back to the old ways because they are what we are used to; there needs to be a complete change in how some people approach those who come in the door. "

**"Open your mind and ears and heart. Encourage people to speak up and explain the experiences they had. Get all the education you can on the recovery model. Commit to frequent and repeated training of staff and the peers you hire. Expect and encourage organizational change. Relinquish the firm control that managers often are tempted to exert; in many areas it will not be appropriate. Learn to live in the discomfort that accompanies the new. Don't try to do it on the cheap; significant financial resources will need to be used to achieve the results that are possible having peers in your organization."*

"If you give us the space to be creative and really do our jobs, the impact can be huge."

Additional Misperceptions & Concerns About Implementation

We've covered a lot of areas to support you as you create peer roles in your agency. As you've read through the materials, you may have found that certain myths, misperceptions or concerns surfaced or are still nagging at you. So, before we close, let's look at some common ones:

Concern	Resolutions
If peer roles are all about developing relationships and sharing experiences then they won't understand the importance of boundaries and confidentiality.	e Peer worker boundaries are different than clinical team members due to the nature of the work, but they do exist. Certification training will frequently cover this topic. e Peer workers are subject to the same policies and procedures as the rest of the team. e Peer workers are in control of the aspects of their experience that they choose to share. e Negotiating boundaries and confidentiality in recovery supporting relationships can be challenging for all team members. e Supervision and support will make space for reflection on issues like boundaries and confidentiality.
Peer workers cannot work full time due to potential loss of benefits.	e Not all peer workers are on benefits. e HR should provide the same amount of support regarding Social Security benefits as with other insurances to their employees. e Include part-time jobs or job-sharing. e The employer's role is to create positions while it is the applicant's role to decide if the position matches his/her particular needs. This is the same whether or not applicants have lived experience.
Peer workers cannot work full time due to the level of responsibility and stress.	e Many peer workers are more than able to work full-time positions. e The interviewing process should include looking into the applicant's past work experiences, to ascertain experience level with working full-time. e Many other applicants for non-peer roles may have issues that compromise their ability or experience with working full-time.

Peer workers aren't professional workers.	e Peer workers should have gone through training prior to hiring or within the first 6 months of hire, if doable. e Certified peer workers typically have a professional Code of Ethics, as well as professional best-practice standards. This parallels other professional positions.
They won't be able to handle the stress of working.	e A common myth is that working is too stressful for people with psychiatric diagnoses. In reality, much of the research has demonstrated that work is, at least, no different than not working and, at best, therapeutic and healing. e Unemployment, social isolation and poverty is frequently more stressful than work. (Marrone &. Golowka, 1999)
People who have had similar experiences will 'trigger' peer workers.	e Peer workers who cannot hear the lived experience of another are not far enough in their recovery to perform the peer worker role. e Most peer workers have heard the stories many time before and are not overwhelmed by them. e Supervision should support the peer worker to clarify issues when there is a specific type of experience that becomes triggering (as it would be for all employees)
Peer workers are incapable of doing the same work as other practitioners.	e The role is not the same as other practitioner's, and doing the activities of another role would often be in conflict with the definition of 'peer support.' e Good peer workers are highly skilled individuals who are capable of doing many things, but have specifically chosen to work in a peer role
Peer workers will become unwell or relapse.	e It is possible but the same is true for all workers. e Some evidence suggests that fulfilling a peer worker role can support and enhance personal recovery.

Peers cannot handle the administrative demands of the job.	This has been shown not to be the case: Peer workers are capable of completing needed paperwork associated with administrative tasks. A greater challenge for employers is understanding how traditional documentation may conflict with the peer worker role, and making the needed policy changes and/or adjustments.
Given that peers are not professionals, they will invariably cause harm to individuals that the other staff members will have to undo.	Any staff member at any rung of the ladder can be an employee who brings harm to people receiving services and distress to an agency. Good hiring practices, regular supervision and internal protective policies are what's needed to ensure that any sub-par employee is easily recognized and terminated.
This big push for the use of peer workers combined with shrinking budgets means I may be replaced by a peer worker.	The peer worker role compliments, but does not duplicate, any other role within the traditional mental health system. Workers in other roles don't need to fear that peer workers will re-place them.

References:

Alaska Peer Support Consortium (2013).*Peer support 101.*

Marrone, J., and Golowka, E. (1999). *If work makes people with mental illness sick, what do unemployment, poverty and social isolation cause?* Psychiatric Rehabilitation Journal, 23(2), 187-193.

Smith, L. and Bradstreet, S. for the Scottish Recovery Network (2011). *Experts by experience: Guidelines on developing peer support.* Retrieved from http:// www.recoverydevon.co.uk/download/Guidelines_on_developing_peer_support_-_Scotland.pdf

Conclusion

We thank you for taking the time to review the 'provider' side of this handbook, and encourage you to check out the other side when you have time!

If you have questions, please contact us at info@psresources.info

If you have additions, subtractions or edits to suggest, please also e-mail us as we expect that this handbook will evolve over time.

Be sure to also visit www.psresources.info for the most up-to-date version and other related materials.

Just a handful of other websites you may want to check out include:

- **Foundation for Excellence in Mental Health-**A website dedicated to raising funds, but also disseminating information and research about best practices in mental health care-www.mentalhealthexcellence.org
- **Hearing Voices USA-**A website full of information on the Hearing Voices movement and nationally available trainings and resources-www.hearingvoicesusa.org
- **Intentional Peer Support-**A website focused on Intentional Peer Support (IPS) training, its basic concepts, values and resources-www.intentionalpeersupport.org
- **International Association of Peer Supporters-**A website focused on peer roles, trainings and resources-www.inaops.org
- **Mad in America—**A website full personal stories and perspectives on peer roles and the mental health system– www.madinamerica.com
- **Madness Radio-**A website full of radio interviews on mental health, peer support and other relevant topics
- **Mindfreedom International-**An international organization focused on the stories, rights and strengths of people who have 'been there'-www.mindfreedom.org
- **National Coalition for Mental Health Recovery-**A website full of resources on the efficacy of peer support (http://ncmhr.org/downloads/References-on-why-peer-support-works-4.16.2014.pdf) and other relevant information-www.ncmhr.org
- **National Empowerment Center-**A national technical assistance center website offering resources and information on a variety of related topics, webinars and beyond (including a listing of statewide peer-to-peer organizations: www.power2u.org/consumerrun-statewide.html)-www.power2u.org
- **National Mental Health Consumers' Clearinghouse-**A national technical assistance center website offering resources, trainings, webinars, etc.-www.mhselfhelp.org
- **Peerlink-**A national technical assistance center website offering resources, trainings, webinars, etc.-www.peerlinktac.org
- **PeersTV–** A Youtube channel with lots of relevant interviews and personal stories-www.youtube.com/user/peerstv
- **Transformation Center-**A Massachusetts-based peer-to-peer organization that offers a supervisory training for individuals supervising peer roles-www.transformation-center.org
- **Western Mass Recovery Learning Community-**A peer-to-peer organization offering nationally available trainings and resource information– www.westernmassrlc.org