A Brief Guideline to Developing "Peer" Recovery Support Services

This guideline is offered to help agencies in their planning process as DMHAS embarks to reorganize case management services to include a level of care that is primarily delivered by self identified persons in recovery. It is not intended to be fully comprehensive or the definitive conclusion on the topic of developing peer supports. It is simply a jumping off point intended to help agencies in their own decision making process. The term "peer" is used liberally throughout the document for simplicity's sake, but it is important to note that self identified persons in recovery who are hired as agency staff are not truly "peers" with the clients that they serve. The role expectations of these paraprofessionals demand certain limits and respect of boundaries that are not required of peers in the truest sense of the word.

"Peer Supports" refers to a process of helping based, in part, on a shared lived experience or identity, and the knowledge gained from overcoming those challenges.
Research on organized peer support programs have been shown to improve outcomes across a number of health conditions including treatment retention & adherence, reduction in utilization of acute services, an increase in positive health related behaviors, and self reported hope and optimism of managing health conditions (1).

Many provider agencies have already successfully involved peer delivered services as a part of their continuum of care. Some are already involved with case management teams, others are coaching clients in articulating person centered, community membership goals in their service plans and helping people in recovery make those connections. Self identified persons in recovery already provide a wide array of services that enhance and amplify the benefits of traditional services. Other clinicians, supervisors, and agency leaders have chosen to disclose their experiences of recovery in order to "put a face" on recovery and combat prejudice. These agencies have lived through the "growing pains" and found that having peers as providers keeps their organizations grounded in the values and spirit of recovery oriented services.

Assessing Agency Readiness

Developing peer support services presents new administrative and attitudinal challenges to an agency workforce which must be thoughtfully considered in the planning process. Providers should assess the level of readiness in their organization to take on the challenges of introducing peer services, or using existing peer staff in new roles.

- How strongly does an agency adhere to recovery principles and language
- What is the level of involvement for persons in recovery to participate in agency committee work, strategic planning, board membership
- Does the agency promote program participants in using self-help groups
- Does the agency host self help groups and foster strong relationships with self help and other grass roots organizations
- Are persons in recovery involved in training staff
- Does the agency support the use of appropriate self disclosure in clinical or educational interactions
- Are clinical supervisors comfortable in providing guidance around the therapeutic use of self disclosure
- Does the agency foster a welcoming environment that communicates equanimity and seeks to minimize the power differential in staff/client

relationships (example: The agency does not have segregated restroom facilities for clients and staff)

For a more in depth discussion on fostering integration of peer support services within an agency go here: http://www.hcbs.org/files/147/7315/Peer_Supports_Policy_Brief2.doc

(1) White, B., & Mandara, A., (2002) *A review on research on the effectiveness of self-help mutual aid groups* in Chapter 5, Self - Help Group Sourcebook (7th edition), American Self - Help Clearinghouse

Brainstorming the Service Design
A multi-stakeholder approach including persons in recovery, family, direct care staff, agency leadership, and other community partners should be utilized to gather input and ideas about the service design. Partners should be provided with information and data concerning the current service array, geographic penetration, access determinants, and other findings necessary to generate informed suggestions concerning peer service design. Special attention should be devoted to identifying service gaps that peer services could fill. How could peer staff serve as a bridge to other components of the agency? How could peer staff contribute to strengthening a recovery oriented approach at the agency?

- What specific services will peer staff provide
- Who will be eligible for these services
- How many staff will be needed to fulfill demand
  - Full time
  - Part time
  - Per diem
- What will the hours of operation be
- Where will services be located
  - Space issues
  - Proximity to other services
  - Physical accessibility to focus population
  - Supplies, vehicles, etc.
  - Community focus
  - Co-location with other community institutions
- What are the optimum behavioral health outcomes for this level of service
- How will peer staff be employed to help the agency advance a recovery oriented approach to services
  - Provide staff training
  - Serve on agency quality improvement and other committees
  - Consult with teams on engagement, approach, language
  - Consult with leadership on strategic goals
  - Serve as a liaison with advocacy and grass roots consumer organizations
  - Assist staff with recruiting persons in recovery, family, and others in ongoing agency activities and initiatives

Agencies need to identify who will provide the leadership to the project, assuring that these individuals have adequate authority to implement necessary changes and direct other staff persons in support roles.

For more about peer support program design look here:
http://www.hcbs.org/files/147/7308/PeerSupportsPolicyBrief1.doc

Program Description and Operations Manual
A detailed program description should be developed and circulated among stakeholders for additional feedback and comment. The program description should include, in addition to items listed above, an organizational chart, budget, funding source(s), reporting requirements, and other vital programmatic components.

For one example of a program description look here:
http://mentalhealth.vermont.gov/sites/dmh/files/FuturesPeerSupport/DMH-Futures_Peer_Support_VCA_Description.pdf

Peer service programs should create an operation manual for the benefit of staff working in the program which is made available to other agency staff so that they, too, will understand how the program functions, how services are provided, how to make referrals, key contacts and other important information. The operations manual should include copies of relevant agency policies when referenced. Master copies of program forms should be included in the manual.

A blank template of an operation manual from the Canadian Ministry of Health looks like this: http://www.communityventures.org/PoliciesAndProcedures/9-07%20Operations%20Manual-Blank%20Outline.pdf

Creating a Job Description
A detailed, specific job description is necessary to clearly communicate the expectations and qualifications demanded in the peer specialist role. The role should be designed in such a way that the accumulation of experience and additional training/education will allow an individual to advance up a career ladder or be prepared to assume different roles and experiences in the agency.

There exists a training and certification process for Recovery Support Specialists through Advocacy Unlimited, Inc., called Recovery University. Persons in recovery who desire this certification will obtain instruction in the skills needed to provide a range of supports and resources for individuals in recovery. The certification also permits agencies to bill Medicaid for services Recovery Support Specialists provide to individuals under the Money Follows the Person and Home and Community Based Services waivers. Contact Advocacy Unlimited for more information at 860-667-0460.

A sample job description from the Veteran's Administration can be found here:
http://www.magellanhealth.com/training/peersupport/magellanmodule1/graphics/job.pdf

Hiring Issues
Before undertaking recruitment and hiring, agencies should be willing to consider a number of issues unique to peer provided services.

Will the agency consider hiring current/former service recipients or not?
The advantage of hiring current or former service recipient is their familiarity with agency services and other community resources, as well as the relationships they have developed. Doing so, however, makes boundary management some what more complicated. If this is the case agencies should develop:
- A policy regarding existing social relationships with other clients. Peer staff should not be expected to terminative supportive friendships they currently enjoy with other clients of the agency, but it should be made

clear that they cannot provide individual services to these people nor should they initiate new relationships with other service recipients.

- A policy not to blend work with services and supports. It will be tempting for a case manager, for instance, to conduct clinical work, paperwork, make appointments, etc., with a peer support staff they are assigned to while this person is on duty; for the sake of convenience. This needs to be strongly discouraged and protocols should be established to keep these two roles clear- such as wearing an ID Badge only when on duty, signing in for appointments as other clients do when arriving for clinical services, or arranging appointments by telephone from home.
- Special medical record security should be afforded to peer staff to ensure their privacy. One example is to have their record kept locked in a supervisor's office accessible only to those clinicians providing direct services to the individual.

Most agencies utilizing peer staff prefer to "hire from within" and have adopted simple and effective steps to minimize role confusion. Sometimes peer staff will elect to receive services elsewhere after a period of time, but for many, due to geographical location, this is simply not an option.

Choosing to exclude current and former service recipients from the hiring pool minimizes role confusion, however the learning curve and adjustment to the agency and community is considerably steeper. Also, accommodating treatment needs tends to involve more time away from duties because of travel.

Will there be flexibility in scheduling be available to accommodate treatment?
As most behavioral health services are offered during daytime hours, how will ongoing treatment needs be addressed? Are traditional staff with ongoing health concerns allowed to flex their schedules for expectable, routine care in order to preserve paid sick leave?

Does the agency understand the ADA and provide reasonable accommodations to its employees?
Like any employee with certain documented conditions, agencies must provide a measure of flexibility in adapting schedules, work environments, and other aspects of the employment experience so that persons with disabilities can successfully perform essential work functions.

How will the agency communicate to staff the need to honor peer staff decision making around self disclosure?
Self disclosure needs to be a thoughtfully considered, therapeutic intervention based on the relationship the peer staff has with each individual they work with. While it is understood that peer staff are self identified people in recovery, that is all that other staff at the agency need to explain. It is highly inappropriate for staff to "fill in the blanks" with other clients based on their personal history with the peer staff. Remarks such as, "I'm sure you'll like working with her, she's got the same diagnosis as you", or, "I remember when he was homeless", while perhaps well intentioned, need to be swiftly responded to in supervision. A person's individual recovery story is theirs alone to share in the context of the service relationship with the individual and under appropriate clinical supervision.

Selection processes

Interview and hiring committees should obviously not include staff members who have a prior service relationship with an applicant. Recruitment ads should encourage persons in recovery to apply. While it is not legal to ask in an interview whether someone has a behavioral health condition, many agencies have found such questions as "what experience do you have that you think helps prepare you to be successful working with people with mental health problems?"- as an opening for people to choose to self disclose. Requiring certification as a Recovery Support Specialist from Recovery University as a job qualification is one way to avoid this dilemma.

If drug screening is part of the selection process candidates must be given and opportunity to explain and verify medical prescription of benzodiazepines, opiate replacement substances, and the like.

Some providers have suggested a psychological screening or testing be required of peer specialist job candidates to assure stability and fitness for duty. Unless this is *already* required of *every single employment candidate for every job* this would not only be illegal, it may also be found insulting and demeaning and deter recruitment of qualified candidates. Employment decisions need to be based on candidates' qualifications as they relate to the job requirements.

Training, Orientation, & Supervision
As with any new employee, considerable attention should be provided to thoroughly train and orient recovery support specialists to the expectations and processes an agency uses to manage employee conduct and provide quality services. Additional training for existing staff may be needed to help them understand the role of peers in programs and how to respect the people providing these services.

Ongoing supervision is necessary for all employees to maintain a high level of quality in service provision and address problems before they become hard to manage. A strong understanding of the therapeutic use of self disclosure and ethical management of dual roles is especially important for the recovery support specialist.

Providing opportunities for members of this paraprofessional discipline to meet as a group to talk candidly about the challenges they face and share strategies for managing their duties is highly recommended. Agencies may consider if they wish to encourage participation in the National Association of Peer Specialists or similar professional organizations (see below).

http://www.naops.org/

http://www.peerspecialistallianceofamerica.org/

Additional Resources

There is a wealth of research and other materials regarding using self identified persons in recovery as service providers. Here are some materials you may find useful.

http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/peer%20support%20practices%20final.pdf

http://www.bhrm.org/guidelines/salzer.pdf

http://www.parecovery.org/documents/Pillars_of_Peer_Support.pdf

http://www.upennrrtc.org/var/tool/file/33-Certified%20Peer%20Specialist%20Training%20-%20PDF.pdf

http://www.upennrrtc.org/var/tool/file/213-FINAL%20CPS%20REPORT.pdf

http://www.rand.org/pubs/technical_reports/2008/RAND_TR584.pdf