City of Philadelphia
DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

ACHARA CONSULTING

yale program for recovery and community health

Peer Support toolkit

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How to Use This Toolkit

The Peer Support Toolkit is an interactive PDF that presents key information in brief reads, yet preserves your opportunity to delve deeper into subjects—as your time and interests dictate—**with just a click.**

The interactive format makes it easy to access content in an order that makes sense to you and to skip over content you don't need in the moment. At the same time, this toolkit retains the essential benefits of a PDF format. For example, you can share this file by email and print individual pages or the document as a whole. You can also use the "find/search" feature to search this toolkit by keyword just as you would any PDF.

The toolkit is organized in four modules, each addressing specific implementation issues relevant to agencies in various stages of integrating peer support services.

The toolkit is designed to be downloaded to a device and opened with Adobe Acrobat.

Please send correspondence about this toolkit to info@acharaconsulting.com.

Each module has promising practices with links to associated **tools or resources** to assist implementation.

Resource

Resources are links to materials not included in this toolkit.

A diving icon invites you to take a **"deep dive"** into a subject.

Click on the link in the paragraph associated with this icon for more information or a more nuanced discussion about a topic.

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Module 2: Interviewing & Hiring

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Toolkit design by Susan Hanson, Chicago

A Word from Dr. Evans

Over the last ten years, Philadelphia's stakeholders have worked tirelessly to create a shared vision of a recovery- and resilience-oriented system of care. It has been no small undertaking to begin implementing the sweeping changes necessary to align our system with that vision. One of these extensive changes has been the integration of peer support services into our behavioral health treatment organizations. Now, more than a decade later, we have numerous promising practices that have emerged from this work and just as many lessons learned along the way.

We have witnessed the extraordinary power of peer support services to improve the experience and outcomes of people seeking and using behavioral health services. The ways in which certified peer and recovery specialists have been utilized in Philadelphia vary widely. Many of them work to promote wellness, reduce stigma, increase access to care, enhance life skills, provide education, and walk side-by-side with individuals as they build or rebuild meaningful lives in their communities. Regardless of their specific role, we have found that peer support staff can also vastly enhance organizational culture, adding a crucial element that complements but in no circumstances replaces clinical care: the element of hope. Through their lived experience, peer staff are a constant reminder that recovery is real and possible, regardless of one's circumstances and the limitations imposed by one's behavioral health condition. Importantly, peer support staff also address two key issues that have long-hounded the behavioral health community: (1) the need to attract individuals to treatment and services well before their behavioral health conditions exact painful tolls on individuals, families, and communities, and (2) the need to move beyond treatment settings and support individuals in the communities in which they live, work, and play.

The past decade has also taught us that peer staff must be more than merely present in an organization; in order to maximize their impact, they must become a fully integrated part of the service team and play an integral role in service planning and delivery as well as in organizational leadership.

A fundamental takeaway from Philadelphia's experience is the need for organizations to prepare for the integration of peer staff before peers are hired. Given that peer support services

are still relatively new, those who want to onboard peer staff may not know how to best introduce and integrate them into their organizations. This toolkit provides the information, resources, and tools to help organizations anticipate and avoid potential misunderstandings and intra-organizational culture clashes. Another key lesson drawn from experience is that organizations will benefit from investing time in envisioning and communicating a clear role for peer staff in their organization.

I am very pleased, therefore, to share this Peer Support Toolkit with you. The toolkit incorporates the learning and wisdom of numerous stakeholders—peer supports, treatment providers, administrators—who shared their insights and advice through focus groups and interviews. I thank them all. Many of the promising practices and tools included in this kit were also generously shared by these Philadelphia providers. We believe peer support staff are among the most powerful and also the most untapped resources available to behavioral health systems. Although the transformation of our behavioral health system is still in progress, we are pleased to share our experiences to date and hope that this toolkit will be a catalyst for continued innovation in Philadelphia and beyond. Thank you for continuing the effort to promote recovery, resilience, and self-determination for all.

Arthur C. Evans, Jr., PhD, Commissioner
Department of Behavioral Health and Intellectual disAbility Services

A Word from Dr. Achara-Abrahams

It has been an honor to support the system transformation efforts within Philadelphia's behavioral health system for the past decade. Several years ago, Philadelphia DBHIDS adopted "recovery, resilience, and self-determination" as the overarching aim for the city's behavioral health service system. With this clear goal, DBHIDS began a comprehensive process of examining services and supports and bringing all aspects of the system into alignment, including fiscal and policy strategies, quality improvement processes, workforce development, and service delivery. Philadelphia's system transformation is ongoing, and while they have celebrated many successes along the way, stakeholders also recognize that there is still much work to be done.

One of the most exciting initiatives has been the integration of peer support services into the behavioral health system. This effort has demonstrated the many possibilities that arise when administrators, providers, people in recovery, advocates, allies, and family members work toward a common goal. Early on, before there were any guidelines on how to integrate—and pay for—all peer support staff, many of Philadelphia's mental health and substance use disorder treatment providers embraced the opportunity to integrate people with lived experience into their treatment settings both as volunteers and as paid staff. These early adopters witnessed firsthand the tremendously positive impact that peers can have on their organizations and especially on the individuals they serve. These providers were supported by advocacy organizations such as PRO-ACT, Mental Health Association of Southeastern Pennsylvania, and the Family Consumer and Family Taskforce, whose staff were dedicated to infusing the system with peer and family support services.

Together, Philadelphia's stakeholders have made tremendous progress. Numerous challenges and promising practices have emerged along the way, and it is a privilege to have the opportunity to document some of these. I believe that people with lived experience working in peer support roles are among the most powerful untapped resources in our healthcare system today, and I hope that this document contributes to the continued evolution of a recovery-oriented behavioral health workforce.

Ijeoma Achara-Abrahams, PsyD
Achara Consulting Inc.

Acknowledgments

This toolkit is based on an initial draft developed by Dr. Larry Davidson, at the Yale Program on Recovery and Community Health, which has been updated and expanded by Dr. Ijeoma Achara-Abrahams and her team at Achara Consulting: Eugenia Argires, Brooke Feldman, Kris Rusch, Jennifer Sears, and Pamela Woll. DBHIDS Deputy Commissioner Roland Lamb and Sean E. Brinda, Manager of the DBHIDS Peer Culture and Community Inclusion Unit, oversaw the development and production of the toolkit.

Sponsor

Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) extends a special thanks to Lonnetta Albright and Rafael Rivera, Co-Directors of the Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC), and the entire team at the Great Lakes ATTC. Their generous support helped make this toolkit possible. The Great Lakes ATTC has been on the forefront of promoting recovery-oriented services and systems and has previously partnered with DBHIDS to develop several related monographs.

The sponsorship of this toolkit represents another demonstration of their continued commitment to advancing the adoption of recovery-oriented services and systems. We appreciate the leadership role that they have served in the field and are honored to have partnered with them in this project.

Great Lakes (HHS Region 5)
ATTC
Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Local Contributors

Over the past decade, many individuals, providers, and stakeholders in Philadelphia participated in focus groups, listening sessions, work groups, committees and boards, and process improvement efforts to assist in the development, delivery, and refinement of peer support services. The pioneering experiences of Philadelphia's behavioral health stakeholders and the lessons drawn from those experiences inspired and informed this toolkit.

DBHIDS would like to recognize in particular the leadership and guidance of the Mental Health Association of Southeastern Pennsylvania and the Pennsylvania Recovery Organization – Achieving Community Together (PRO-ACT). These two advocacy organizations have partnered closely with DBHIDS to reduce the stigma associated with behavioral health conditions in Philadelphia and have collaborated to enhance the availability and quality of treatment and recovery support services in the system. These two organizations have each developed curricula for training Philadelphia's Certified Peer Specialists and Certified Recovery Specialists and continued to collaborate with the department to implement training for peer staff along with other workforce development initiatives.

Other organizations and groups have made significant contributions that continue to shape our perspectives and approach to the delivery of peer support services. These include:

Alliance of Community Services Providers
Consumer Satisfaction Team
Consumer & Family Task Force
DBHIDS staff
Family Resource Network
Focus group & listening session participants from across the system
Office of Addiction Services Advisory Board
Philadelphia DBHIDS Recovery Advisory Committee
Philadelphia Coalition
Philadelphia's network of behavioral health providers

Providers that generously contributed resources for the Toolkit include:

COMHAR
Horizon House
JEVS Human Services
NHS
North Philadelphia Health Systems
Northeast Treatment Centers
PHMC Interim House
Wedge Recovery Centers

While the Department has hosted numerous focus groups and community listening sessions that have helped to align services with a recovery-oriented approach, several organizations and numerous individuals in recovery also participated in targeted focus groups, which were geared at clarifying the content needed for this toolkit. DBHIDS wishes to thank the following organizations—and their peer staff—for sharing their successes, challenges, and insights.

Al-Assist
Belmont Comprehensive Treatment Center
Community Treatment Teams
Consortium Inc.
Girard Medical Center
Horizon House
Kirkbride Center
Mental Health Association of Southeast Pennsylvania
Northeast Treatment Centers
Northwest Human Services
People Acting To Help (PATH)
PRO-ACT
Project H.O.M.E.
Resources for Human Development
Temple Episcopal Hospital's Acute Living Unit
Warren E. Smith Health System

Without their perspectives, this toolkit would not have been truly grounded in Philadelphia's experience.

Background and Purpose

Over the last ten years, stakeholders in Philadelphia have experienced a reawakening of hope, vision, and purpose as we collectively strived to implement sweeping changes in how we envision, develop, and deliver behavioral health services in our city. During this time, people in recovery, treatment providers, system administrators, advocates, family members, and other allies joined forces to lead a recovery-focused system transformation. The impetus for this system-wide transformation came from the convergence of several national and local trends.

National Trends

At the national level, an accumulating body of research demonstrated that characterizations of serious mental illnesses as progressive, deteriorating conditions were false. In fact, many—if not most—people diagnosed with serious mental illnesses experience significant improvements over time and live full and meaningful lives in their communities, particularly when provided with an individualized and sufficient array of nonclinical services and supports (Anthony, Cohen, Farkas, & Gagne, 2005). Similarly, our conventional approaches to treating severe substance use disorder were not consistent with emerging research about the illness. Although severe alcohol and other drug problems have long been depicted as chronic illnesses, they have been treated primarily as acute conditions within increasingly brief, episodic treatment models (Dennis & Scott, 2007). Research indicated that shifting to a recovery management approach, along with integrating an expansive array of recovery support services, significantly enhances recovery outcomes for people with substance use disorder (White 2004, 2008).

Federal reports such as the landmark *Mental Health: A Report of the Surgeon General* (1999) and *Achieving the Promise: Transforming Mental Health Care in America* (2003) by the President's New Freedom Commission on Mental Health also raised awareness about the need for significant change to the mental health delivery system. The Bush report described the system at the time as "fragmented and in disarray," leading to "unnecessary and costly disability, homelessness… and incarceration." The Commission emphasized that the current approach to services "simply manages symptoms and accepts long-term disability" (US Department of Health and Human Services [HHS], 2003:1). The subsequent Federal Action Agenda (HHS, 2005) articulated the level and scope of changes that behavioral health systems across the country needed to adopt.

> *Mere reforms to the existing…system are insufficient. … [T]ransformation is not accomplished through change on the margins but, instead, through profound changes in kind and in degree. Applied to the task at hand, transformation represents a bold vision to change the very form and function of the mental health service delivery system… Transformation…is nothing short of revolutionary.* (*HHS, 2005*)

Bolstered by this research, people with behavioral health conditions pushed back against systems that did not support their desire to be fully integrated members of their communities. They challenged service-delivery models centered on biopsychosocial stabilization, symptom management, and maintenance, and called instead for treatment approaches and service systems to be reorganized around the concept of recovery.

Local Influences

At the local level, several milestones paved the way for Philadelphia's transformation efforts, including the closing of the Philadelphia State Hospital in 1990, which represented a shift from institutional to community-based care. The development of Community Behavioral Health in 1997 set the stage for the integration of all behavioral health services in Philadelphia by bringing together in one plan the previously separate funding streams for mental health and addiction services. The Philadelphia Coalition and the Alliance of Community Services Providers are local provider advocacy organizations that have been valued partners in leading the transformation of Philadelphia's behavioral health system.

Progress continued in 2005, when Dr. Arthur Evans initiated the current recovery-focused system transformation effort. Through numerous community meetings and focus groups, as well as through the work of the Recovery Advisory Committee, the Office of Addiction Services Advisory Board, and the Consumer and Family Task Force, Dr. Evans created opportunities for stakeholders to come together and create a shared vision of a radically transformed service system. The rise and expansion of peer-run community advocacy organizations such as Mental Health Association (MHA) and PRO-ACT were also extremely important to the process of creating a transformed service system. As a result, a decade-long process ensued to align services, supports, and administrative functions with the goals of promoting wellness, sustained recovery, and a meaningful life in the community for everyone.

Peer Support Services Come of Age

Early in Philadelphia's transformation process, services provided by people in recovery from mental illness and substance use disorder were recognized as a powerful catalyst for systems change and as a conduit for enhancing recovery outcomes and the quality of life of individuals receiving services. Many of these efforts were led by MHA and PRO-ACT, who together rallied the recovery community in Philadelphia and raised the voice of the people with lived experiences.

Successes were not easily accomplished, however. At the start of the transformation process in 2005, there was minimal guidance available about effective strategies to integrate peer staff into various kinds of treatment settings. Philadelphia treatment providers learned through trial and error. Although many of our providers proceeded with high determination, they all encountered challenges along the way. Some providers reported that too little attention to organizational preparation and lack of clear roles for peer staff slowed their progress. Others reported experiencing challenges related to not having clear hiring practices, supervisory protocols, or career ladders for peer staff. Some agencies disclosed a need to focus on processes for ensuring peer staff become fully integrated, valued members of their service teams.

Philadelphia is not the only city endeavoring to improve its behavioral health services through the integration of peer staff. The variability in emerging peer models throughout the country represents both a strength and a potential pitfall in the field. There is little consistency with regard to language, roles, training, and credentialing requirements, and limited implementation guidelines for those integrating peers into clinical settings. Another challenge—particularly in many mainstream treatment services, where a conventional medical model still prevails—is protecting the role integrity of those providing peer support services within treatment settings. There are few implementation guidelines to help those who seek to integrate peers into clinical settings.

During the spring of 2014–2015, we conducted several focus groups with agency executive directors, peer supervisors, and peers support staff throughout the city to continue identifying promising practices, lessons learned, and strategies for overcoming challenges. This toolkit was informed by the collective wisdom of the staff in these organizations, coupled with best practices described in the behavioral health literature.

We developed this toolkit so that agencies across the nation may benefit from many of the lessons learned in Philadelphia over the past decade as well as serve as a catalyst for the next level of Philadelphia's continued recovery-focused system transformation process.

"TRANSFORMATION... IS NOTHING SHORT OF REVOLUTIONARY."

Is This Toolkit for You?

Behavioral health peer support is generally provided through three major organizational profiles:

1. **Peer-run organizations**, in which all staff are in recovery
2. **Peers hired into existing roles not reserved for those in recovery**, such as a psychologist, social worker, nurse, psychiatrist, or addiction counselor
3. **Peers hired into new peer support roles** within treatment organizations

This toolkit was developed specifically to assist those interested in the third approach.

The first two profiles present their own challenges, and staff at those agencies may nevertheless find some of these tools useful. This toolkit, however, was developed to support behavioral health agencies in the process of integrating peer providers into their services settings. Tools in this kit will help agencies to recruit, retain, and effectively deploy people in recovery in a variety of new peer support roles.

The **target audiences** for this toolkit are **administrators, directors, and supervisors of treatment organizations** who have recently hired (or plan to hire) peers into new support roles with the agency.

Others, including peer support staff, will also find this toolkit useful.

Why Integrate Peer Staff?

Peer support services play a central role in recovery-oriented systems of care for at least three reasons.

First, mental illnesses and substance use disorders are stigmatized in our society, and many people with these conditions have been discriminated against as a result. Prejudice and discrimination can lead people with behavioral health disorders and their allies to feel hopeless, helpless, and despairing. Against a cultural backdrop of misinformation, pessimistic prognoses, and destructive stereotypes, peer staff provide invaluable, concrete proof of the reality of recovery. They instill hope that recovery is possible and demonstrate to people with behavioral health conditions, their loved ones, and behavioral health practitioners alike that decent, caring, and worthwhile people experience psychiatric and substance use conditions and—with sufficient and appropriate support—recover from them, as well.

Second, in part due to the stigma and misinformation described above, the majority of people with behavioral health conditions do not seek or receive timely or effective treatment. Only one in three people with a serious mental illness will access specialty mental health care, and only one in ten with an addictive disorder will access specialty substance use treatment. As living and breathing examples of recovery, peer support staff can attest to the utility and effectiveness of treatment, rehabilitation, and support. Peers are effective in engaging people into care who otherwise would not choose to access it, acting as a bridge between people in distress and what many people have experienced to be an impersonal, imposing, and confusing system.

Third, by virtue of their own life experiences, peer support staff will have learned valuable lessons about how to access and use behavioral health care services and how to manage and overcome behavioral health conditions. This experience enables them to act as role models for people who are just entering into, or are early in, their own recovery. Peer support staff will have learned how to navigate the health and social service systems in their community, how to advocate for themselves within behavioral health programs, and how to persevere in the face of bias and discrimination. In addition, peers will have learned ways of managing, living with, and recovering from their own behavioral health conditions. This experiential knowledge complements the clinical and technical knowledge that practitioners acquire in their training and practice, and offers valuable assistance, especially to those struggling to contend with conditions that respond in only limited ways to existing treatments.

Philadelphia stakeholders have found that there are considerable benefits for treatment agencies in hiring peer staff that extend well beyond the benefits reaped by the people receiving the peer support services and the peer staff themselves. These benefits range from the cultivation of a more supportive and nurturing culture for everyone, to increases in the degree to which existing, non-peer, staff find their work to be enjoyable, meaningful, and gratifying.

Thanks to the work of numerous organizations over the past decade, Philadelphia now has formal peer support services in crises response centers, hospital-based inpatient units, outpatient and residential programs, and detoxification facilities. Together we have accomplished a tremendous amount and demonstrated the significant impact that peer support services can have in treatment settings. Through the transformation of

our Day Programs into Community Integration Resource Clinics, for example, we learned that peer staff play a critical role in supporting people with mental health challenges through the process of navigating new environments and developing meaningful lives for themselves within their communities. During the first year of the program, integrating peer staff and aligning the service philosophies with recovery-oriented approaches led to a 36 percent reduction in visits to crises response centers.

Some of the early adopters in our system, such as NorthEast Treatment Centers (NET) and Horizon House Inc., have consistently demonstrated that successfully integrating peer staff improves retention, staff morale, and most importantly outcomes.

For example, when NET integrated peer staff into their IOP program, attendance increased from 50 percent to 75 percent in a matter of weeks. According to Joe Schultz, Vice President-NET Adult Behavioral Health:

> *When the IOP counselors began to see folks attending more frequently, staying connected longer, and overall doing well, their morale increased as well as their appreciation for the peer specialists. The peer specialists at the NET are now essential members of the clinical team. Our successful outcomes are linked to the integration of peer supports, which in turn enhances a culture of recovery at NET that emphasizes empowerment, resiliency, and self-determination. Our integrated recovery support teams include peer specialists, case managers, and individual and group counselors. These teams reinforce and sustain our recovery-oriented culture by staying focused on their primary goals to motivate, engage, and retain people in recovery.*

Since 2008, more than 500 individuals with a history of homelessness who also have behavioral health conditions have transitioned from chronic homelessness into permanent housing, and 86 percent of them remain housed with significant improvements in their health status. According to Jacqueline Blatt, Director of Horizon House Journey of Hope:

> *Our Journey of Hope project showed us that integrating peer support along with aligning the treatment philosophy with a recovery-oriented approach can have a dramatic impact on both treatment outcomes and quality of life. The relationship and rapport that the participants have with the peer specialist is a primary contributing factor to the high retention and completion rates, as well as bridging strong relationships between participants and clinical staff.*

Even when stigma and discrimination no longer exist and access to behavioral health care has become uncomplicated, timely, and responsive, peer staff will likely continue to be valued for sharing their experiential knowledge of recovery and for teaching, encouraging, and modeling effective self-care.

As **living and breathing examples of recovery**, peer support staff can attest to the utility and effectiveness of treatment, rehabilitation, and support.

A Brief History of Peer Support in Behavioral Health

Many people think that peer support services are a relatively recent development within behavioral health, emerging from the Mental Health Consumer and New Recovery Advocacy movements in the early 1990s. In reality, the history of what we now refer to as peer support spans centuries, crosses continents, engages a wide array of treatment settings, and is shaped by the diverse culture and norms of the communities it benefits.

In mental health, records indicate that a primary mechanism for the development of "Moral Treatment" by Philippe Pinel and his colleagues in France in the late 18th century—at the birth of psychiatry—was the hiring of recovered patients to staff the new moral treatment asylums or retreats. In fact, it was actually Pinel's colleague, an ex-patient named Jean-Baptiste Pussin, who first unchained the mental health patients of Paris in 1797 while instituting other reforms. Pinel hired recovered patients to staff the new treatment asylums to ensure that the hospital staff were respectful, humane, and compassionate in their treatment of the patients. Prior to this advance, patients were shackled in chains and periodically beaten.

Harry Stack Sullivan, a founder of American psychiatry, chose the strategy of employing ex-patients again in the early part of the 20th century when he hired people who had recovered from acute psychotic episodes to staff his programs. Peer support then played a central, if implicit, role in the therapeutic milieu models of inpatient and day hospital care through the 1970s, although in this case the peers were not paid for their contributions to one another's recovery; these contributions were considered part of their own treatment.

The new wave of peer support services in mental health emerged from the consumer, survivor, and ex-patient movements that began in the 1960s, around the same time as the civil rights movement, gay rights, the women's movement, and the Native American movements. The movements were fights for self-determination driven by anger about inhumane treatment and oppression.

Although the asylum reforms of the 1800s led to treatment that was more humane than the brutal medical orthodoxy preceding it, most iterations of Moral Treatment's paternalistic structure asserted that a patient had a better chance of recovery if treated like a child, and best served by an asylum operating as a strict, well-run household. Generations of asylum directors became the strict but benevolent father figure establishing comprehensive sets of rules enforced with continual patient surveillance and simple systems of reward and punishment. Critics in the early 1900s argued that the Moral Treatment did not cure patients but instead made them dependent on the doctor and the asylum. Accordingly, the actual chains of the early asylums were replaced with the invisible shackles of submission and conformity, thus making true recovery, freedom, and empowerment even more elusive (Foucault, 1965).

In the early 1990s, peer support emerged in its contemporary form in mental health and has virtually exploded across the country, with the number of peer staff in mental health programs reaching the tens of thousands. Peer staff fulfill a variety of roles and serve numerous functions in these programs, from providing traditional services (such as case management or residential support) to offering entirely new services (such as teaching people how to use Wellness Recovery Action Plans). Research conducted on the services and supports provided by people in mental health recovery has been consistently positive, providing evidence that peer support can engage people effectively into care, enhance the role people play in their own care, instill hope and a sense of self-confidence, decrease substance use and despair, and increase self-care and satisfaction in a number of life domains, including social support (Davidson, Bellamy, Guy, & Miller, 2012). As a result of this research, the Centers for Medicare and Medicaid Services recognize peer support as an evidence-based practice that can be reimbursed.

There has been a similar history in the substance use field. Although the New Recovery Advocacy Movement is a relatively recent development in the addiction field, earlier forms of peer support by and for people with addictions have existed at least since the early 1800s. Early in the 18th century, Native American tribal leaders, many themselves in recovery from alcohol addiction, formed "Sobriety Circles" presaging by almost 200 years self-help mutual aid societies such as Alcoholics Anonymous (White, 1998). Drawing upon their personal recovery journeys, leaders from various nations launched abstinence-based movements calling for the complete rejection of alcohol and a return to tribe-specific ancestral traditions and spiritual values. The earliest of these movements included the Handsome Lake Movement (1799), the Indian Prophet Movements (1805–1830s), the Indian Shaker Church (1882), and the Native American Church (1918). This tradition continued into the contemporary period with the "Indianization of Alcoholics Anonymous," the Red Road, and the Native American Wellbriety Movement (Vick, Smith, Herrera, & Rope, 1998; White, 2009).

In addition to these cultural revitalization movements, people in recovery were hired to serve as guides for others seeking recovery as early as the 1840s, when they worked as temperance missionaries, aides, and managers of inebriate homes 1860s–1900. William White also documents that paid peer helpers worked as Keely Institute physicians (1890–1920); "friendly visitors" within the Emmanuel Clinic in Boston (1906), lay alcoholism psychotherapists (1912–1940s); managers of "AA farms" and "AA rest homes" (19402–1950s); halfway house managers, and paraprofessional alcoholism counselors and professional "ex-addicts" (1960s–1970s) (White, 2004).

Similar to the mental health arena, the evolution of peer support in addictions has been an international phenomenon that is reflected in recovery mutual aid movements such as the Blue Cross in Switzerland (1877), Germany's Kreuzbund (1885), France's Crois d'Or (1910) and Vie Libre (1952), Austria's Sukunft/Abstinence Union (1926), Swedish Links (1945), and Polish Abstainers Club (1960) (White, 2004).

In its contemporary form, recovery coaching in addiction, as well as a number of other peer-run programs and organizations, build on this rich history to provide an important complement to existing substance use disorder treatment programs. Peer recovery support can be provided as an effective bridge into treatment, as a potent augmentation to treatment, and as a valuable post-treatment resource that enables people to maintain the gains they have made in treatment, thus helping people to initiate, achieve, and sustain recovery. Peer-delivered recovery support services have proliferated throughout the United States over the last decade and have found an especially warm welcome in the City of Brotherly Love. Rather than targeting substance use, triggers, or relapse directly (as in treatment), these services aim to increase a person's recovery capital so that he or she will have the motivation, support, and skills needed to develop and maintain a commitment to long-term recovery.

People with high personal vulnerability (family history, early age of onset of use, traumatic victimization), severity, and complexity (co-morbidity) and low recovery capital have not fared well in acute models of treatment but are better positioned to initiate and sustain their recovery when provided with a full complement of recovery support services. Peer-based recovery support services constitute an essential element in this menu of supports.

Preparing the Organizational Culture

module 1

Preparing the Organization: Why Do It?

Promising Practices:

Preparing the Organization: Why Do It?

Philadelphia's treatment providers learned a critical lesson about the importance of preparing their organizations and staff prior to hiring peers. As behavioral health providers, administrators, and allies, we share a passion for improving the health and well-being of the individuals we serve. Yet, with numerous urgent and emergent needs demanding our attention daily, we rarely feel that we have the luxury to be reflective, to plan, and to prepare. So when providers in our system recognized peer support as an opportunity to fulfill unmet needs, many immediately ran with the concept, rolling out trainings and hiring peers. Only in retrospect did many of us fully appreciate the importance of the preparation period.

Medical v. Recovery-Oriented Approaches

Averting an organizational culture clash is a prime reason to take time upfront to prepare an organization for peer support staff. Peer staff are integrating into settings that were historically grounded in a medical model of treatment. The conventional medical model is far removed from a recovery-oriented approach. Historically, practitioners using a medical model have focused on biopsychosocial stabilization and symptom management. In recovery-oriented approaches, providers seek to understand people with behavioral health disorders in the larger context of their historical, political, and socioeconomic circumstances. Assessment and service planning strategies in recovery-oriented approaches are much broader in scope than in medical models and address multiple life domains to identify and maximize all potential levers for change (White, 2008). In recovery-oriented approaches, the locus of power shifts from the service provider to the person receiving services, and decision making is collaborative rather than hierarchical.

> "In hindsight, we did not do enough upfront preparation work. This was our earliest and biggest struggle. [A lack of preparation] resulted in complaints from counselors and misunderstandings and [mis]perceptions. Counselors objected to and resented the integration of peer support staff. We now see upfront preparation as a critical process and realize that you always have to keep in mind new staff; therefore, preparation is a continuous process. Since that time, our Peer Support Specialists have proven their net worth to both the clinicians as well as those we serve and are viewed as an adjunctive and necessary component for promoting meaningful recovery."
>
> Tom Baiers and Lois Figueroa, JEVS Human Services

Given the dissimilar philosophical underpinnings of these two approaches, deliberate attention must be given to organizational culture to avoid the confusion and tension that can quickly surface and impede progress.

Staff Concerns

Helping staff understand how peers will function in the organization is another benefit of preparation. Although peer support services have evolved over a significant period of time, peer staff in treatment settings are still relatively new. Agency staff often have questions and concerns about bringing peer staff on board. These concerns range from the relatively concrete—Do peer staff get keys?—to the more complex, such as managing boundaries and self-disclosure. Identifying and addressing these concerns is a critical step in creating a shared vision of the peer support role.

There is another important reason why leaders need to prepare their agency for the integration of peer staff: Despite a desire to have a positive impact in the lives of people with behavioral health conditions, treatment providers in Philadelphia—as elsewhere in the United States—work in a health system that is embedded in a culture with a history of overt discrimination against people with behavioral health conditions. Given that many misconceptions about behavioral health disorders remain prevalent in our culture, it is likely that many staff have internalized at least some negative beliefs and biases about people who have them. The problem is not only that prejudices continue to stigmatize the people they serve, but also that unexamined staff biases can be a detriment to people pursuing recovery. "Addicts are manipulative," is just one example of a persistent cultural bias. If treatment providers accept that people with substance use disorders cannot be fully trusted, it will feel natural not only to regard with suspicion their stated motives for their goals, but also to take it upon ourselves to determine their readiness to get a job, start a relationship, move into independent living, and so on.

We all have biases of one kind or another, and providers are no exception. Although our most deeply entrenched biases skew our perspectives of entire groups of people, they typically operate outside of our awareness. Helping staff identify and shift these beliefs is fundamental to the delivery of recovery-oriented services. We cannot truly empower people to live full, meaningful lives in the community if we have low expectations of their potential, for example, or believe that our role is to take care of them. Before long, we find that we have inadvertently perpetuated dependence and isolation rather than community connections, independence, and resilience. Subtle shifts in thinking can make the difference between truly empowering others and depriving them of power, opportunity, and choice.

The following practices and accompanying resources and tools will help your organization address these and other issues and lay the groundwork for change.

Resource

For a full description of recovery-oriented approaches to treatment services, see the Department of Behavioral Health and Intellectual disAbility Services Practice Guidelines for Recovery and Resilience Oriented Treatment.

Practice 1. Communicate Senior Leadership's Commitment to a Recovery-Oriented Service Philosophy

Embedding peer support services into treatment settings is more than just adding a new service option; it is a culture change that aims to improve service delivery across the entire organization (see box 1). The inclusion of peer support shifts the focus and nature of treatment services themselves. As a result, the administrative context in which staff deliver those services (organizational policies, budgets, evaluation practices, and so on) must also align to support recovery-oriented services.

All of these changes, and more, require the active efforts and strong support of agency leadership in articulating a clear vision of where the agency is headed, addressing the inevitable barriers to achieving that vision, and institutionalizing the changes so that they endure.

Understandably, the prospect of initiating agency-wide culture change can be daunting. Where to start? Regardless of where the impetus for transformation originates—direct care staff, service users, advocates, or others—to fully reorient your agency culture, the transformation must be endorsed and promoted from the top down, as well as implemented from the bottom up.

"For culture change to occur, a ... prerequisite is for someone in a position of significant authority and leadership in the agency to announce that a recovery-focused transformation process is an agency-wide priority."

Joe Schultz, Clinical Director, NET

Box 1. Three Approaches to Systems Change

1. Additive Approach

In this model, organizations add recovery services such as peer-led support groups, peer-based telephonic aftercare, and other services as discreet options to supplement existing treatment practices, which themselves remain unchanged.

2. Selective Approach

The selective approach strategically aligns services in certain programs or levels of care with a recovery-orientation, but not all. Within the targeted elements, both clinical and nonclinical services become more recovery-oriented and the administrative context is aligned to support this orientation, while non-targeted aspects of the organization continue to operate as usual. The changed components of the organization may be viewed as pilot projects or recovery projects, but they do not influence the broader culture of the organization.

3. Transformative Approach

True transformation integrates recovery-oriented principles throughout the entire entity under consideration. Both clinical and nonclinical services and supports are aligned with a recovery-orientation. The transformative approach ensures that all administrative and operational processes, policies, and fiscal strategies support the delivery of recovery-oriented services. As such, is it a value-driven culture change throughout the entire organization or system.

For a deeper discussion about ROSC transformation, see Achara-Abrahams, Evans, & King, 2010.

Forming a Change Management Team that includes members with a variety of skills, perspectives, and circles of influence can help organizational change take root (see box 2). Ensuring that Change Management Team members are fully committed to peer support integration, understand their change management role, and are empowered and equipped to plan and implement change sends a strong message about commitment to organizational transformation.

For a summary of elements required for successful transformative change, see *"Leading Change: Why Transformation Efforts Fail"* by John P. Kotter (1995).

Box 2. Sample Change Management Team

- Board member
- Top organizational leader, such as the CEO or executive director
- Strategic planning or organizational change expert (staff or consultant)
- Medical director
- Clinical director
- Clinical supervisor
- Peer staff from within or outside of the organization
- Members of a Peer Advisory Council, if one exists
- Certified peer support staff from outside organization
- Organizational change expert (staff or consultant)
- Human Resources Department representative
- Performance improvement staff

Peer Staff Integration Leadership Commitment Checklist

Practice 2. Solicit the Perspectives of People in Recovery, Family Members, and Staff Early in Your Process

Today's behavioral health professionals are continually asked to adapt to the rapidly shifting priorities, practices, and regulations of a health care industry that seems to be always in flux. In this context, it is important to help behavioral health staff understand that the integration of peer support services is not a mere service-delivery fad; it is a fundamental and lasting change in organizational culture.

Stakeholders in Philadelphia learned that one of the most effective ways to instill a sense of urgency about integrating peer services is to solicit input from staff, people in recovery, and family members and other allies through focus groups and community listening sessions. Focus groups typically bring together members of a particular stakeholder group, which can be defined as broadly or narrowly as purposes require. For instance, when soliciting staff views, one organization may get good feedback from a focus group involving a cross-section of staff, whereas another organization may find it more productive to have one focus group of clinical staff, another focus group of administrative staff, and so on.

Stakeholders in clearly defined focus groups may express their views more candidly than those in mixed groups. Organizations that want to hold mixed focus groups with a variety of stakeholders should ensure the groups are led by a facilitator skilled at diffusing tension. The facilitator must be able to help participants weave a shared vision from their differing points of view so that the sessions feel constructive. Not everyone will share all the same opinions even in narrowly defined groups. But all participants should feel heard and respected.

Community listening sessions commonly bring treatment staff, people in recovery, family members, and allies together to listen to one another. When staff have opportunities to hear directly from people in recovery about what helps and hinders their recovery, they often walk away re-energized and with a different perspective on what people in recovery want and need. Staff's renewed awareness fosters change at both the individual and the agency levels.

Focus Groups and Listening Sessions Facilitator's Guide

Sample Questions About Integrating Peer Support

Practice 3. Provide Resources, Ongoing Training, and Continued Opportunities to Orient Current Staff

Often times, service providers focus on training new peer staff but neglect to support existing staff in re-aligning their approach to services with a recovery orientation. During training, staff often increase their awareness of the need for recovery-oriented services and many begin to explore how they could operationalize a recovery-oriented approach in their day-to-day work. The Philadelphia Department of Behavioral Health and Intellectual disAbility Services partnered with the Yale Program for Recovery and Community Health to provide treatment providers and other stakeholders with Recovery Foundations Training, a two-day participatory training that introduced the concepts of recovery-oriented practice. Each training included folks from across DBHIDS, provider staff, people in recovery, and community-based organizations. Initial training is critical and lays the foundation for a deeper exploration of needed practice changes and for implementing peer-based recovery support services. Many agencies in Philadelphia, in fact, went on to conduct additional training within their organizations.

> "If there is no transformation inside of us, all the structural change in the world will have no impact on our institutions."
>
> Peter Block, *Stewardship*, 1996

Resource

"Life Beyond Treatment: Recovery-Oriented Systems of Care" (DVD series featuring a training by William White and Ijeoma Achara on recovery management and recovery-oriented systems of care.)

The series is available upon request from the Southeast Addiction Technology Transfer Center. Call 404-752-1016 or order online.

Practice 4. Conduct an Agency Walk-Through

Many of Philadelphia's providers found that conducting an agency walk-through was helpful in transforming their service setting. Walk-throughs created an opportunity for staff members to see their organization's processes with new eyes.

Take a look at the walk-through activity and think about whether it would be useful to conduct a walk-through of a certain aspect of your agency: for example, walking in the front door, going through intake, requesting records, selecting services.

> "The North East Treatment Center participated in a NIATx change project. Staff conducted a walk-through of the intake and admission process. As a result of participating in the walk-through, we experienced what our participants experience. The admission process typically lasted two days before people were connected to treatment, and during that time they were overwhelmed and confused. Our data showed that only 50 percent of individuals returned for day 2 when they were admitted. The change project was to assess and do same day admissions. The strategy was to include a Peer Support person in the waiting room to welcome, support, and assist with the intake and assessment process. The peer provider also walked the individual to the group session that day. By offering same day admissions, the second day show rate increased to 90 percent."
>
> Joe Schultz, Clinical Director, NET

NIATx Walk-Through Activity Facilitator's Guide

Observation Guide for Role Players

Resource

NIATx

Practice 5. Examine the Extent to Which Agency Language Is Recovery Oriented

Another important area for assessment is the language your agency uses to talk about behavioral health clients, conditions, and programs. Many professional organizations, government bodies, and media outlets have now endorsed the use of person-first language as a way to counter longstanding discriminatory attitudes toward certain groups. Person-first language emphasizes the personhood of individuals and does not reduce the entirety of their being to a single state or condition. For example, instead of saying "He's an alcoholic," we can highlight personhood and the treatable nature of an individual's condition with phrases such as "He's living with alcoholism." The recovery movement has strongly endorsed person-first language.

Although some staff may object to what they perceive to be "politically correct," science tells us that language shapes as well as reflects perception. The perceived potential of someone described as "crazy" will differ from someone described as "living with schizophrenia." Similarly, be aware of language that refers to groups of individuals as if the boundaries separating us from them are impermeable. "The homeless," and "the mentally ill" are two such common phrases that tacitly reduce individuals to conditions they are currently facing. Phrases such as "people experiencing homelessness" and "people living with mental illness" draw attention to the fact that individuals are facing issues that society has a role in addressing.

The language with which we refer to the people we serve matters not only on a cultural level, but also on an individual level. If we continually use terms that imply our clients are totally taken over by or reduced to their illnesses, they may come to view themselves as having

> "The Journey of Hope Program was initially known as the Chronic Homeless Program. The peer staff and members believed in the power of strength-based language and questioned DBHIDS about why their program was called the Chronically Homeless Program and requested a more strengths-based name. DBHIDS challenged the peer staff and members to rename their program. The members decided to use a contest to rename the project. A panel of people receiving services was organized and suggestions were submitted to the panel for review and selection. A woman from the Womenspace project submitted the winning name. As her prize, she received a huge starter kit at the completion of treatment when she transitioned into her own apartment. This included pots, pans, silverware, bedding, etc. That is how the name Journey of Hope came to be. The peers receiving services also subsequently decided that they wanted to rename the program's workshop series from the *Relapse Prevention Workshop* to the *Recovery Support Workshop*."
>
> Timothy Sheahan,
> DBHIDS JOH Project Manager

diminished capacity to recover or lead satisfying lives. As Patricia Deegan explained, "Once a person comes to believe that he or she is an illness, there is no one left inside to take a stand toward the illness. Once you and the illness become one, then there is no one left inside of you to take on the work of recovering, of healing, of rebuilding the life you want to live" (1993, p. 9).

The Language Evaluation Activity will help show whether and where your organization could make improvements.

Resource

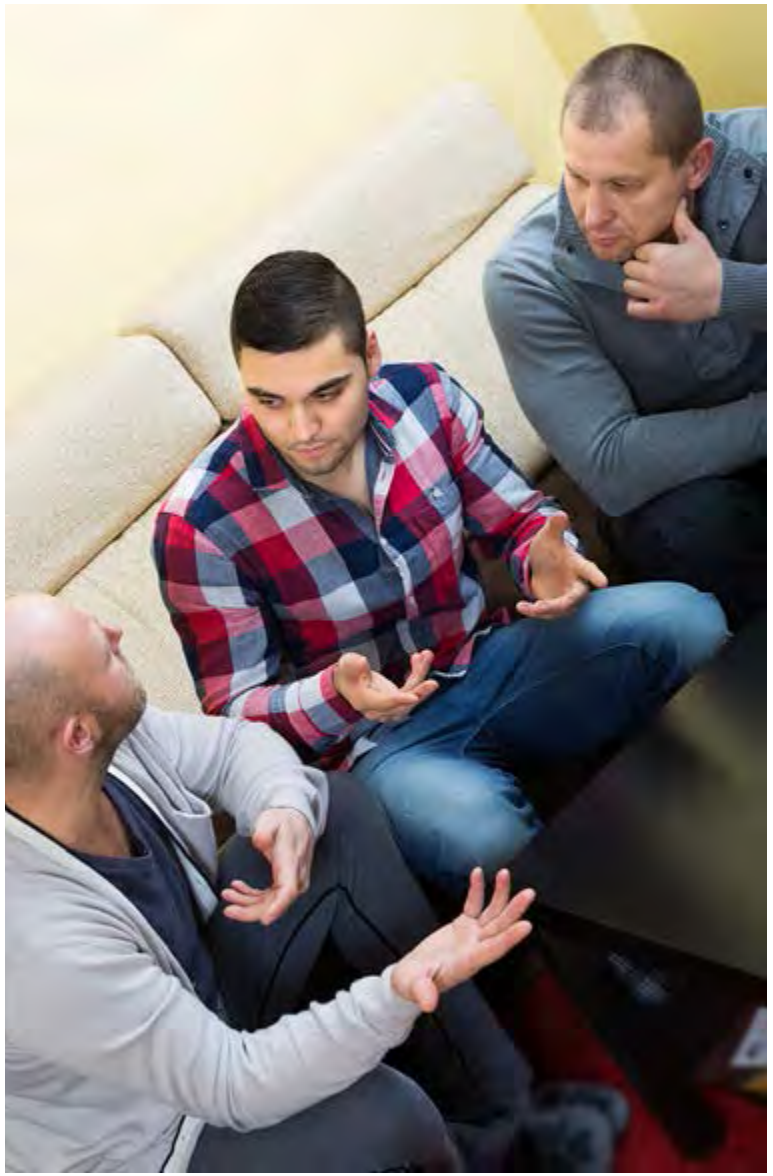
White, W. (2006a). The rhetoric of recovery advocacy: An essay on the power of language

The Language Evaluation Activity Facilitator's Guide

Language Evaluation Worksheet for Role Players

Practice 6. Anticipate, Address, and Reframe the Concerns of Existing Staff

> **"Clinicians were uncomfortable with the presence of certified peer specialists in their program."**
>
> *Peer Staff*



Faced with the prospect of working with peer staff for the first time, clinical staff likely have concerns and questions about what to expect. Without accurate information, myths and biases may prevail. Leaders who have integrated peer staff into behavioral health agencies around the country have found that several concerns regularly arise. Some of these concerns are discussed below.

Aren't peer staff too "fragile" to handle the stress of the job?

Jobs in behavioral health are stressful for everyone, and peer staff are no different. Self-care is therefore an important practice for *all* behavioral health staff, not just for peer staff. It is true, however, that peer staff are asked to take on the additional burden of disclosing some of their most personal experiences and to use these experiences to help others pursue recovery. Recovery is hard, taxing, and ongoing work. Far from being fragile, people who have gained mastery over their own behavioral health conditions could instead be viewed as having a considerable amount of persistence and resilience.

Don't peer staff relapse?

All employees, including peer staff, may need time off because of illness. And staff who have not disclosed a behavioral health disorder may nonetheless take time off because of it. The same expectations for sick time and accommodations for illness should be applied to all employees, including peer staff. Regarding the belief that high-stress occupations may precipitate relapse, research has consistently shown that people are less likely to relapse when working than when they are experiencing prolonged involuntary unemployment.

Can peer staff handle the administrative demands of the job?

Although some people joining the peer workforce may have little work experience or limited educational attainment, on-the-job training can give peer staff the opportunity to learn the administrative elements of their jobs. If needed, additional supports can enable them to perform required tasks. For example, people with cognitive impairments or limited literacy could record their notes orally and have them transcribed. The individual could partner with human resources personnel to design other accommodations. Any person assuming a new role and level of responsibility may benefit from additional support for a period of time to ensure that they are confident in fulfilling the requirements of their role. Many new hires would benefit from a transition period during which they receive targeted training and support to position them for success. Peer staff are no different.

Won't peer staff cause harm by breaking confidentiality or saying the wrong things to individuals receiving services?

Peer staff, like other employees, are expected to conform to policies and regulations regarding confidentiality and Health Insurance Portability and Accountability Act laws. Peer staff are just as responsible as any other employees for keeping personal information confidential. With the training and supervision afforded all staff, there is no reason to believe that confidentiality will be any more difficult for peer staff than for anyone else. Nor is there any reason to believe that trained and supervised peer staff will be more likely than other staff to say the "wrong" things. On the contrary, by virtue of their life experiences as service recipients, peer staff may be more attentive to protecting people's privacy and using appropriate language when talking to their peers.

"In the beginning, people thought I would not be able to handle the stressors of the work. Over time, I showed that not only could I handle it, but I was good at it, and they came to see me as a champion for change."

Peer Staff

Won't the addition of peer staff make my job harder rather than easier?

Peer support provides an important and useful complement to existing behavioral health services and supports. Peer staff can be especially effective in engaging people into care and acting as a bridge between service users and other staff. Their work has been found to lessen the load carried by other practitioners, enriching the lives of individuals while allowing other staff to concentrate on their respective areas of expertise.

Will peer staff take all of our jobs? Will I be replaced by a person in recovery?

There is no justification for behavioral health staff to worry about being replaced by peer staff. There has long been a lack of qualified staff available for behavioral health positions. The health care system is projected to continue to expand rapidly over the coming years, making this longstanding gap in the behavioral health workforce even more significant. Regardless, peer support services complement, rather than replace, clinical and rehabilitative services. In states where labor unions play a prominent role in care delivery, concerns about job security have been addressed, in part, by including new peer positions under the scope of an appropriate union.

Use the Myth or Fact Activity to open conversations with your staff about these and other concerns.

- Myth or Fact Activity Facilitator's Guide
- Myth or Fact Worksheet
- Myth or Fact Answer Sheet

Practice 7. Conduct an Agency Self-Assessment

Early in Philadelphia's system transformation process, many of the participating treatment organizations conducted agency self-assessments. In many organizations, these assessments helped to initiate a dialogue about the need for change and led to the identification of critical next steps. Several tools already exist that you can use to conduct a thorough self-assessment of different aspects of organizational culture to see where you are, and where you may need to go, in your organization's transition to a resilience and recovery orientation.

These tools address such domains as the recovery orientation of services; the involvement of service users, family members, and allies in positions of influence at different levels of the agency; the customer service orientation of the facility and staff; and honoring and celebrating diversity.

An effective approach to addressing unconscious biases that affect service delivery is to cultivate an inclusive organizational culture that honors and celebrates diversity. Here we are talking not only about diversity in race, culture, ethnicity, and sexual orientation—although these certainly remain important—but also diversity in life experience and challenges. To protect and honor the rights of people with behavioral health conditions, both service users and staff, it is helpful to emphasize the benefits of diversity and embed inclusion strategies in all aspects of your work. To provide you with a starting point, we have included the Diversity and Inclusivity Organizational Self-Assessment Tool, developed by the YWCA of Minneapolis in partnership with the Charities Review Council.

Another area for organizational self-assessment is the degree to which an agency's culture promotes health and wellness, not only for service users and family members, but for all parties involved. That is, how supportive and healing is the environment in which staff work and people receive

services? For example, because behavioral health services are often underfunded and the priority for financial resources typically goes to service provision, little attention may be paid to the physical spaces that you utilize, the messages that are conveyed by your facilities, and whether a sense of wellness is promoted as people navigate the physical spaces of your organization. The Environmental Wellness Tool was developed by the University of Texas at Austin Center for Social Work Research. It is intended to help you identify some ways to improve the overall experience of both staff and persons served.

The Recovery Self-Assessment (RSA) is a tool designed to identify organizational strengths and areas for improvement regarding the provision of resilience and recovery-oriented care. The RSA contains concrete, operational items to help agency staff, service users, family members, and allies to identify practices in your agency that facilitate or impede the promotion of resilience and recovery. We have adapted the RSA so that your team can use it as a checklist and discuss opportunities for growth as well as existing strengths.

The RSA is a helpful starting place for exploring the current orientation of your organization, because when asked about shifting to a recovery-oriented approach, most staff respond that they are already recovery oriented.

Resource

To learn more about the RSA and view different versions of the instrument, visit the Yale Program for Recovery and Community Health.

- Diversity and Inclusivity Organizational Assessment Tool
- Environmental Wellness Tool
- Recovery Self-Assessment Facilitator's Guide
  - RSA Checklist
  - RSA Checklist Planning Companion
  - RSA Sample Goals
  - RSA Discussion Guide
  - RSA Action Plan for Change
  - RSA Activity Debriefing

Practice 8. Examine and Create Shared Expectations Related to Boundaries and Ethics

In many places, enthusiasm about the role of peer support staff is tempered by concerns about harm that might come to service recipients. The potential for harm is present in all health and human service roles, and peer support roles possess unique complexity. Two dynamics that contribute to this complexity are highlighted here.

For a comprehensive discussion, readers are encouraged to review Ethical Guidelines for the Delivery of Peer-based Recovery Support Services by William White in partnership with the Philadelphia Department of Behavioral Health and Intellectual disAbility Services and Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT).

Peer support staff's relationships with individuals typically last longer than counseling relationships, and peer support services are more likely than clinical services to be delivered in the client's natural environment. These factors contribute to the complexity of managing boundaries and ethics in peer support services (White, 2007). Peer staff do not have the natural boundaries that the walls of an agency provide. Navigating relationships in the community setting can introduce more intricate nuances to client-staff relationships. For instance, how should peer staff respond when the people they support attend the same AA meetings that they attend, or when someone they are supporting invites them to join them at a social event as a friend?

A second source of complexity stems from the fact that the ethical guidelines that dictate the actions of clinical staff often do not apply to peer staff. Although traditional helping professions (physicians, nurses, psychologists, social workers, addiction counselors) emphasize demarking hierarchical

boundaries and maintaining detachment in service relationships, peer-based services rely on reciprocity, collaboration, and minimizing social distance between helpers and those being helped (Mowbray, 1997; White, 2007). As a result, generalizing ethical standards from traditional clinical professions could inadvertently lead to the over-professionalization and commercialization of peer support roles.

These dynamics underscore the need for a clear set of ethical values and standards to guide the delivery of peer-based recovery support services. White and his colleagues maintain that ethical guidelines for peer support staff should flow directly from the needs of those seeking recovery and from the values of local communities of recovery (White, 2007). Philadelphia's recovery community organizations, the Mental Health Association of Southeastern Pennsylvania and PRO-ACT, have both developed ethical guidelines for peer staff that inform the discussion in this section.

Encourage Staff to Use a Model of Ethical Decision Making

Issues related to boundaries and ethics are so diverse and expansive that they cannot be entirely addressed within any single document. White and colleagues suggest that peer staff would benefit from using a framework that provides a model of ethical decision making, rather than an exhaustive list of do's and don't's.

Engage All Staff in Discussions to Create Clarity and Shared Expectations

With the shift to person-centered care throughout all of medicine—including behavioral health—hierarchical, authoritarian relationships are being replaced by collaborative ones in which the person with the condition plays an increasingly prominent and active role. Boundaries remain important in protecting individuals from exploitation, abuse, and violations of their confidentiality. On the other hand, boundaries can be problematic if they impede the development of genuine, trusting relationships or if they convey an artificial or impersonal interest in the individual, thereby diminishing the personhood of the individuals being served.

Until there is consensus within the behavioral health field about how best to approach these issues, your agency must wrestle with them yourselves. These issues are not limited to the scope of practice of the newly hired peer staff, but must be considered for all staff who provide services or supports to clients and family members.

We encourage you to use the Intimacy Continuum tool in staff meetings and supervision activities to engage in a discussion about boundaries, to develop a shared understanding across all staff, and then to expand and refine your policies, as needed.

The following questions can also assist your agency in reexamining and realigning your current policies.

1. What is our agency's current position, whether explicit or implicit, on the nature of the boundaries staff are expected to uphold with respect to clients?
2. Are the boundaries expected to be the same regardless of the role or function of a staff member? For example, are clinical staff and rehabilitative or support staff held to a different set of expectations?
3. What aspects of our current position on boundaries seem necessary to protect and promote the best interests of the people that we serve?
4. Given that all relationships within health care settings are becoming more collaborative and person-centered, are there aspects of our current position on boundaries that also need to change? For example, do we routinely do things that may impede the development of trusting relationships with people, or tend to make some people, including those from certain cultural, ethnic, or racial backgrounds, reluctant to engage in our services?

Communicate that All Staff Are Accountable Employees of the Agency

An overarching principle guiding decisions pertaining to ethics and boundaries is that peer staff must be viewed as accountable employees of the treatment agency. Consequently, peer staff have to abide by agency policies, procedures, and expectations just as other employees must. In practice, for example, this principle implies that peer staff are only to access client medical records as required in order to perform the functions of their job—just like other employees—and that they are bound to protect the privacy and confidentiality of what is in those records—just like other employees.

This principle also addresses concerns about mandated reporting, as peer staff are obligated to report suspected

incidents of child or elder abuse and neglect and any serious, imminent risks a person may pose to self or others, just as any other (nonpeer) staff member would be. Peer staff should be trained to identify such incidents and to report them immediately to their supervisor for review, consideration, and, if appropriate, action. Nothing about the peer staff's status as a peer would change his or her role under such circumstances, and this limitation on confidentiality should be made clear to the people whom peers support. No one should be led to believe that information they share with a recovery coach or peer staff will be kept from other agency staff or leadership when it pertains to abuse, neglect, or serious risk.

In the end, once discrimination against people with behavioral health conditions has been eliminated, we may find that the boundaries we need to maintain in our treatment settings are not very different from those that primary care providers maintain with their patients. Such boundaries will inevitably differ across urban and rural settings, across cultural communities, and even among staff within the same agency. Within behavioral health settings, though, we need to establish boundaries that protect the best interests of the people we serve, but that do not, inadvertently, make them feel less valued than others without behavioral health conditions, or convey that they are incapable of taking charge of their own lives.

- Ethical Guidelines Activity Facilitator's Guide
- Ethical Guidelines Activity
- Four Dilemmas
- Recovery Coaching Intimacy Continuum
- Ethics Activity Debriefing

Note: The tools are from "*Ethical Guidelines for the Delivery of Peer-Based Recovery Supports*" (White, et al., 2007).

Practice 9. Align Policies with a Recovery-Oriented Approach

Agencies often find that some of their policies must be revised to allow for hiring qualified persons in recovery. Below, we discuss policies that commonly must be reconsidered with the introduction of peer support staff. (Aligning policies that pertain to other aspects of peer support is discussed in respective modules.)

Policies Regarding Criminal History

Some organizations have policies stipulating that they may not hire anyone who has a criminal record. Given the disproportionate rate at which persons with behavioral health conditions come into contact with the criminal justice system, and the broad range of charges they may face, organizations may need to replace such a blanket prohibition with a more thoughtful review of each individual and his or her fit with the specific peer support role desired. For instance, some history of nonviolent crime may be a significant asset in some peer support roles, especially when working with individuals in forensic or diversionary settings.

Policies Regarding Educational Attainment

Educational requirements—such as requiring job candidates to hold a high school diploma or higher degree—can be another barrier to hiring peer support staff. Many people in recovery experienced the onset of a mental health or substance use condition during their adolescence or young adulthood, disrupting their formal education. Staff who provide peer support services are legitimized not through traditionally acquired education credentials but through their experiential knowledge and expertise (Borkman, 1976; White, 2009). It is important to note that the experience of having a behavioral health condition does not in an of itself constitute the peer staff's credential. Rather, what is important is the peer staff's ability to extract lessons from that experience and to use the resulting wisdom to promote sustainable change in others. Experiential knowledge does not mean that peer staff do not need training or supervision; it does, however, constitute a vital resource that peer staff bring to their work and relationships with individuals served.

> "I am proud to say that I have worked with and hired many people who have had legal histories or criminal backgrounds, and many have gone on to be good employees."
>
> Sean Brinda, Manager,
> Peer Culture & Community Inclusion Unit,
> DBHIDS

Policies Regarding Dual Relationships

Our conventional practice of prohibiting dual relationships among staff is challenged by the nature of peer support. Peer staff are current or past users of behavioral health services. And they are now behavioral health providers, as well. An agency may at first think that it can overcome this problem by establishing a policy that the agency will not hire anyone for a peer support position who currently receives services

from that agency. But this policy is problematic in a number of ways. First, in effect, the agency would be vulnerable to claims of employment discrimination. In addition, in rural areas, or even within some urban communities, there may be only one agency that is accessible to a person who needs services or from which a person feels comfortable receiving services. To insist that the person terminate his or her treatment relationships in order to be hired is unjustified and sets up additional impediments to employment.

Equally important, perhaps, is that establishing such a policy does not address or bypass the core issue. Peer staff, like all staff, have multiple relationships in their lives. Even prior to being employed, they never were *only* service users or were fully defined as a person with a mental illness or substance use disorder. Similarly, staff are not "just" staff, but play multiple roles in their communities, including as parents, as school board members, as participants in their faith communities, as patients in their own health care, and so on. While a nurse who works for the only hospital in town may not be admitted to her own unit when she needs emergency medical care, she also will not be made to travel 60 miles to the next hospital in order to receive that care. Rather than maintain a simple—and unenforceable—policy banning dual relationships, approach this issue thoughtfully and on a case-by-case basis, considering the preferences and comfort levels of all parties involved. Some states have policies that prohibit previous service recipients from being hired into peer staff roles within certain timeframes. We suggest that these policies should be revisited to eliminate any blanket prohibitions.

Policies Related to Clinical Stability

In the substance use disorder arena, one of the goals of recovery coaching is to help others sustain recovery, so it is common for organizations to require potential peer staff to have a certain period of stability, however defined (e.g., no hospitalizations, detox admissions, or relapses), to qualify for the job. One year of clinical stability or sobriety is a typical qualification for addiction recovery coaching roles. Although such a requirement makes sense at first glance, clinical stability as a condition for hire is the focus of ongoing debate.

One issue is that the Americans with Disabilities Act prohibits employers from considering clinical issues in the hiring process; prospective employers are not entitled to medical information and are prohibited from asking job candidates directly about it. Doing so exposes an organization to charges of discrimination. Another practical consideration is that there is no general agreement about what recovery means for people with many mental health conditions, nor any objective way to measure it; recovery is as unique as the person living it.

For people with substance use disorders, recovery has traditionally been associated with abstinence or reduced substance use, which may make length of recovery easier to measure. But employment contingent on recovery status should account for the fact that addictive disorders are chronic, relapsing diseases. If a person has been in recovery for years and then experiences a slip, does it make sense for him or her to be disqualified from employment, especially given the positive effects employment has on recovery and

the potential for the person to use their experience with a slip a catalyst for change in others?

Given the nature of behavioral health conditions and the nonlinear nature of recovery, an individual's recent clinical status cannot indicate whether he or she can perform the functions of a job. One person may not have been in a hospital for years, but still may not be able to provide peer support, while another person might be able to provide peer support effectively a week after discharge. Hence, all required periods of stability are arbitrary.

The assessment of a person's ability to provide peer support should include a thoughtful analysis of all of the available data that speak appropriately and only to the person's potential job performance. It is not the hiring committee's role to assess the person's health status.

As we will discuss in Module 2 Practice 3, a clear job description that lists the basic qualifications required of the position will help steer the hiring process away from the problematic and amorphous area of clinical status to the more relevant areas of specific job expectations and performance standards.

Practice 10. Clarify Expectations and Roles of New Peer Staff

> **"There was role and title discrimination and a need for a more clear description of what a certified peer specialist was supposed to do."**
>
> *Peer Staff*

Perhaps the single most important thing you can to do to ensure the success of new peer staff is to be as clear as possible about the expectations you have for them with respect to their roles and job performance. Given that peer staff serve in a number of different roles and fulfill a variety of functions, it is incumbent on agencies to be very clear about which roles and functions they are hiring each person for and the ways through which the person will be expected to inspire hope, share his or her recovery narrative, engage individuals seeking services, and model self-care.

Many of the treatment peer staff who were integrated into clinical settings early in Philadelphia's system transformation process indicated that more clarity about their roles would have been extremely helpful as they joined the service team.

Numerous peer staff expressed frustration about being asked to perform duties outside of the scope of their role. They recommended that agencies "train other staff on what Certified Peer Specialists are responsible for and what they are not responsible for."

Without this role clarity, many peer staff struggled to feel that they were integrated and valued members of their service teams.

Based on this experience, agency leaders are strongly encouraged to explore—and engage others in exploring—specifically what peer staff will do, as well as how, for whom, where, over what period of time, and with what expected outcomes. How will leaders, and peers themselves, know when peers are doing a good job and when they may need additional direction or support? How will nonpeer staff know when their new colleagues are doing what they were hired for, and how should they expect this work to affect their own?

As discussed below, expecting peer staff to provide peer support, as simple and obvious as that may sound, does not provide sufficient clarity either for the new peer staff or the existing nonpeer staff with respect to *what* the staff member will be doing while he or she is inspiring hope, sharing his or her own recovery story, engaging a person, or modeling self-care.

Does peer support, for example, take place in an office, at the local coffee shop, in an agency car on the way to and from medical appointments, or perhaps in the person's own home? Do peer staff connect individuals to other community resources, do they work collaboratively with their individuals to develop Wellness Recovery Action Plans (WRAPs) or person-centered recovery/care plans, or do they lead support groups focused on wellness strategies? Are they more like personal trainers who encourage exercise, good nutrition, and smoking cessation, or are they more like case managers who assess and help individuals address their basic needs for housing, income, education, and employment?

Before describing specific functions of peer staff, it is important to establish that the primary role of a peer support staff member is to leverage their personal lived experience with a behavioral health condition in multiple ways. These ways include but are not limited to inspiring a sense of hope that resilience and recovery are possible; demonstrating credibility and earning the trust of people who are reluctant to engage in any form of health care; modeling self-care; encouraging people to take on more active roles in their own lives, health care, and recovery; promoting community integration and an improved quality of life; supporting efforts to sustain wellness; extending the expertise of someone who has successfully negotiated the health care and human services systems to others who are newer to, or less practiced in, the challenges those systems present.

Some of the core functions of peer staff in treatment settings are described in the table below (adapted from White, 2009).

Peer Function	Description
Assertive Outreach	Rather than wait for individuals with behavioral health conditions to "hit bottom" or demonstrate that they are ready and motivated to pursue their wellness, peer staff conduct assertive outreach to those who have never received services and supports, who may be waiting to receive them, or have become disconnected and may benefit from being reengaged. This is one of the roles for which the most evidence of impact currently exists. In addition to physically connecting with people in community settings (that is, outside of behavioral health agencies), outreach also involves removing barriers to receiving care, including bureaucratic red tape and unwelcoming physical environments.
Community Education	Peer staff recognize that the surrounding community is a powerful resource for healing. They counter stigma and discrimination by identifying opportunities to educate the community about behavioral health conditions and the factors that both help and hinder recovery. Through their education efforts, they identify recovery allies who can be leveraged to support recovery at individual, household, family, and community levels.

continued

Peer Functions in Treatment Settings, continued.

Peer Function	Description
Advocacy	Peer staff advocate for participants both within their organization and within the broader community. They also engage in formal advocacy efforts to reduce stigma, increase access to services, and increase the breadth and quality of services.
Empowerment and Leadership Development	Peer staff engage in nonhierarchical, collaborative relationships and support others by helping them clarify their desires and identify relevant action steps. In doing so, peer support staff empower people to make choices and pursue their goals. They also create leadership development opportunities within agencies such as "Peer Advisory Councils" and connect individuals to those opportunities.
Recovery Capital Assessment	Peer staff explore the strengths and assets that individuals bring in support of their recovery from an individual, interpersonal, and community perspective. They support people in identifying potential areas of vulnerability and identify strategies for strengthening these and increasing their recovery capital.
Recovery and Wellness Planning	Recovery-oriented services move beyond the focus on symptom reduction and biopsychosocial stabilization to assisting people with developing full lives in their communities. Peer staff can support people in not only addressing and coping with behavioral health challenges but also with improving their overall quality of life and integrating into their community by supporting them in developing individualized recovery plans. These plans identify goals in multiple life domains along with simple next steps.
Assertive Linkages to Community Resources	Peer staff play a critical role in identifying, mapping, and developing recovery resources, including education, employment, housing, childcare, and others. Peer staff link people to community resources and help them navigate these and other health and social service systems.
Recovery-Focused Skills Training	Peer staff are positioned to help people in their natural communities develop the skills they need in order to integrate into those communities. They also provide life-skills groups in agency- or community-based settings to reinforce new skills, such as problem solving.
Companionship and Modeling	Peer staff provide social support with an increasing emphasis on assisting people in developing their own, sustainable pro-recovery support network. They also provide recreational opportunities in the natural community. These demonstrate that life can be enjoyable with or after a behavioral health condition. Through the companionship that they provide, peer staff promote hope and serve as living evidence that recovery is real.
Crisis Support	Peer staff can provide critical support during challenging times by sharing their lived experience, promoting hope, being present, assertively connecting people with needed resources, and so on.

continued

Peer Functions in Treatment Settings, continued.

Peer Function	Description
Ongoing Recovery Management	Studies document significant variability in recovery outcomes following treatment for episodes of substance use disorder and the erosion of treatment effects over time. Peer staff extend the duration of support services beyond a treatment episode, intensify those services during windows of initial and subsequent vulnerability, and move the locus of support from the treatment environment to the client's natural environment (Godley & White, 2011; White & Godley, 2003). Support is provided in intervals and via a variety of avenues (e.g., in person, by telephone, through text messages, in community, agency, or home-based settings) determined in partnership with the people receiving support.
Health System Navigation	The most recent innovation in peer support is the role of the peer health navigator. A Behavioral Health Navigator supports individuals, their family members, and caregivers and connects them to culturally relevant health services, including prevention, diagnosis, timely treatment, recovery management, and follow up. Navigators also help people develop and implement individualized action plans. The peer support worker who provides navigation uses his or her familiarity with the system itself to create connections, remove barriers, and increase the ease with which people can access needed supports.

The functions described above are not exhaustive and are not performed by all peer staff in all settings. Each organization, ideally in collaboration with individuals seeking services, determines which functions are most relevant and desired for their community.

Given the long history of peer-to-peer service in the substance use disorder arena, it is important that peer services are clearly defined in ways that differentiate them from professional treatment services and from sponsorship in 12-Step or other mutual-aid groups. "Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity" (White, 2006b).

Assessing Role Clarity and Readiness for Integrating Clinical and Peer Support Staff

Practice 11. Clarify the Roles of Volunteer and Employed Peers

Volunteerism can be powerful and beneficial to the people served, the staff of the agency, and the volunteers themselves. For many, volunteerism is seen as a way to "give back" or "be in service"; for some, volunteerism can serve as a step toward entering or re-entering the workforce. When utilizing volunteers, it is important to clarify the roles and expectations of volunteers and to be clear on how they differ from that of paid staff.

Having a formal application, an established scope of activities, along with relevant training, orientation, and supervision processes can help with structuring and setting boundaries around the roles. Differentiating between the tasks, services, expectations, policies, and overall role of paid staff versus those of volunteers will greatly minimize role confusion.

Should Volunteer and Paid Peer Staff Have the Same Responsibilities?

In some organizations, volunteers conduct the exact same responsibilities as paid staff. The nature of the supports provided are the same; the only difference is the number of people supported. For instance, paid staff might work with 20 individuals, while volunteers are assigned 5. We do not recommend this approach for treatment organizations. Although volunteers can supplement and enhance services provided by paid peer support staff, most volunteers do not have access to the same level of training, supervision, resources, and coaching given to employed peer staff.

Volunteers supporting people in treatment would need significant support to navigate the complex situations that they will undoubtedly encounter. Also, one of the key benefits of peer support services is the peer staff's ability to create sustained healing relationships with people. Organizations cannot hold volunteers to the same set of standards related to availability and time commitments that they have for their employed peer staff. This means that people working one-on-one with a volunteer would likely experience significantly more disruptions in the service relationship than they would with employed peer staff.

Thinking Through the Roles of Paid Versus Volunteer Peer Staff

It is recommended that organizations engage staff in the process of thinking through and clarifying the roles of volunteers. Discussion questions follow. (It may be helpful to have someone take notes during the discussion.)

- What are the roles and duties of paid peer support staff?
- Are there some tasks that are low demand but very time consuming?
- Are there important tasks that are not getting done?
- To maximize paid staff time, are there low-demand tasks that could be assigned to volunteers? For instance, could volunteers accompany individuals to appointments, help them fill out applications, make reminder calls or follow-up calls, greet people at the front door, update community resource guides, and so on?
- Considering the current capacity, how many volunteers will you need and how much time would they need to commit?
- Considering the roles that you are considering for volunteers, what types of training will they require?
- Who will supervise the volunteers?
- What will supervision look like?
- How will volunteers interact and partner with paid peer staff? How can we avoid creating hierarchies?
- When working with individuals, volunteers will encounter obstacles or challenging situations. What process needs to be established to ensure that volunteers have immediate access to needed supports when this occurs?
- How should volunteers and employed peer support staff describe and differentiate their roles to the people receiving services?

Summary of Actions Needed to Prepare for the Integration of Peer Support Staff

For a review of the content of this module, refer to the Peer Support Administrative Checklist below. This tool walks you through several of the key steps involved in preparing for the integration of peer support services. With your team, assess your agency's status with respect to each of the items below. (Click in cell to check.)

Preparatory Activity	Not Necessary	Need to Begin	In Progress	Completed
Leadership Establishes a Clear Vision for Transformation				
Focus Group with Staff				
Focus Group with Participants				
Focus Group with Family Members				
Listening Session with Stakeholders				
Foundations Training				
Orientation for all staff				
Review RM & ROSC DVD				
Conduct an Agency Walk-Through				
Model Strengths-Based Language				
Reframe Staff Concerns/Perceptions				
Staff Self-Reflection Exercise				
Agency Self-Assessment				
Diversity and Inclusivity Assessment				
Environmental Wellness Tool				
Clear Set of Ethical Values and Standards Created				

continued

Peer Support Administrative Checklist, continued.

Preparatory Activity	Not Necessary	Need to Begin	In Progress	Completed
Ethical Decision Making Exercise				
Clinical & Peer Staff Have a Shared Understanding of Expected Boundaries				
Policies and Procedures Aligned with a Recovery Orientation:				
• Criminal History				
• Educational Attainment				
• Dual Relationships				
• Clinical Stability				
Role Clarity Focus Groups/Listening Sessions				
Role Clarity Scenario Group Activity				
Role Clarity And Integration Readiness Assessment				
Clear Roles and Value of Peer Supports Established				
Shared Understanding of Partnerships/Collaborations with Nonpeer Staff Established				

Team Discussion Questions

1. Which of these items stand out as particularly important to your team?
2. Are there any items that you have already completed?
3. Which items are you currently working on?
4. Are there items that you previously did not consider that you now realize should be addressed?
5. What are some of your concrete next steps?

Recruiting and Hiring Peer Staff

module 2

Recruiting and Hiring Peer Staff: What's Different?

Promising Practices:

Recruiting and Hiring Peer Staff: What's Different?

In many respects, the recruitment and hiring processes for peer staff is the foundation for integrating quality peer support services within an agency. Identifying candidates who have the core characteristics to be effective peer staff requires intentional recruiting and hiring strategies. For the most part, the process for recruiting and hiring peer staff will be very similar to that used to hire other agency staff. Given their unique roles, however, there are important differences. In this module, we offer a number of recommendations to help you hire the right individuals for your setting and provide you with numerous tools to make processes such as developing job descriptions and interview questions clear and simple.

> **"Since we added Certified Peer Specialists to our Community Integrated Recovery Center teams in 2007, they have been instrumental in helping individuals to realize, through internal strengths and appropriate support, that they are resilient, despite the challenges, traumas, and discrimination experienced."**
>
> Jason McLaughlin,
> Chief Operating Officer,
> Wedge Recovery Centers

Practice 1. Expand Your Typical Search Activities

Where do you find qualified applicants for peer staff positions? Members of the recovery community who are actively involved in the behavioral health system are an obvious starting place. Yet, many people, as they progress in their recovery, move away from the formal, publicly funded behavioral health system in which they began their recovery journey. They may become employed and have private insurance that allows them to receive care in the private sector (where the majority of prescriptions for psychiatric medications are written), they may no longer receive treatment or support at all, or they may have shifted the majority of their support to the self-help/mutual support community. To reach potential candidates who have moved along to new communities, it is important to define the recovery community as expansively as possible. And because people in recovery are members of every community, be sure to also advertise the position through traditional outlets.

Announce your available peer support staff positions through the following:

- Advocacy organizations
- Civic/nonprofit organizations
- Colleges and universities, job boards as well as collegiate recovery programs and recovery community centers
- Community centers, fitness centers
- Colleagues, including those in the private behavioral health and primary care sectors
- Emails and email lists
- Faith communities, including recovery ministries
- Newspaper classifieds
- Online job boards and other online community forums
- Online recovery support communities, including bloggers and advocates
- Peer-run programs
- Self-help/mutual support groups
- Outreach events
- Senior centers
- Social media outlets
- Treatment alumni groups
- Your organization's Web site, newsletters, and staff bulletins
- Youth centers

Practice 2. Involve Non-Peer Staff and Organizational Leaders Throughout the Hiring Process

The more agency staff participate in the hiring process, the more invested they will be in the success of the candidate. As the hiring process evolves, staff will also increase their understanding of the role and the support that new hires will need to succeed in the position.

Involving non-peer staff and organizational leaders in the hiring process may require some training about the concrete functions of the peer position. Creating opportunities for staff to learn and ask questions about peer roles, and offering opportunities for staff to work through any fears and anxieties can increase staff buy-in and foster a welcoming environment for new peer staff.

Another effective strategy for involving a variety of staff is to create a small recruiting and hiring committee. Given that most behavioral health staff already have significant demands on their time, the prospect of participating in another committee or shouldering another obligation can seem less than appealing. To attract staff participation, one point person would need to be in charge of managing the committee, facilitating meetings, reporting to the Change Management Team, and keeping the hiring process moving quickly so that staff involvement is productive and time-limited.

Guidelines for Running a Productive Recruiting and Hiring Committee

Resource

Supervisor's Guide to the Hiring Process

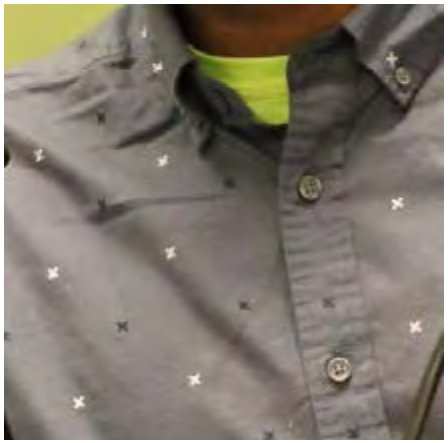
Practice 3. Write a Detailed Job Description

Finding Qualified Candidates

In Philadelphia, although all peer support staff participated in the same training program that made them eligible for employment, the roles that they were hired to fulfill differed considerably among service settings. Providers found that it was not sufficient to identify someone as a recovery coach or peer staff and assume that everyone had a shared understanding of the person's day-to-day functions. Given that peer staff can serve in diverse roles, it is recommended that you invest time upfront in defining the specific role within your work environment and provide detailed examples of the position's core responsibilities. Examples include the following:

- Assisting with the development of wellness recovery action plans and recovery plans
- Community education
- Community resource identification and linkages
- Family education and support
- Recovery management
- Life skills or support group facilitation
- Motivational enhancement
- Ongoing record-keeping and support
- Outreach and engagement
- Participation in team planning activities
- Post-treatment monitoring and support
- Recovery check-ups and coaching
- Recovery education

Providing clarity about the specific functions associated with the employment opportunity will minimize the number of applicants who are not a good fit and expedite the hiring process. It will also assist with establishing and maintaining role clarity within the organization.



Be Clear about the Centrality of "Lived Experience"

Equal Employment Opportunity Commission (EEOC) guidelines allow employers to refer to psychiatric disability within a job description and posting if having had this particular life experience is considered to be related to an "essential function" of the job. This is clearly the case with peer-based positions.

In order to attract people who have lived experience with a behavioral health condition, the job posting will need to specifically include language about applicant's behavioral health status and comfort with sharing their own recovery story to engage, support, and inspire others. Chinman and colleagues (2009) provide the following suggested wording for posting peer-based positions:

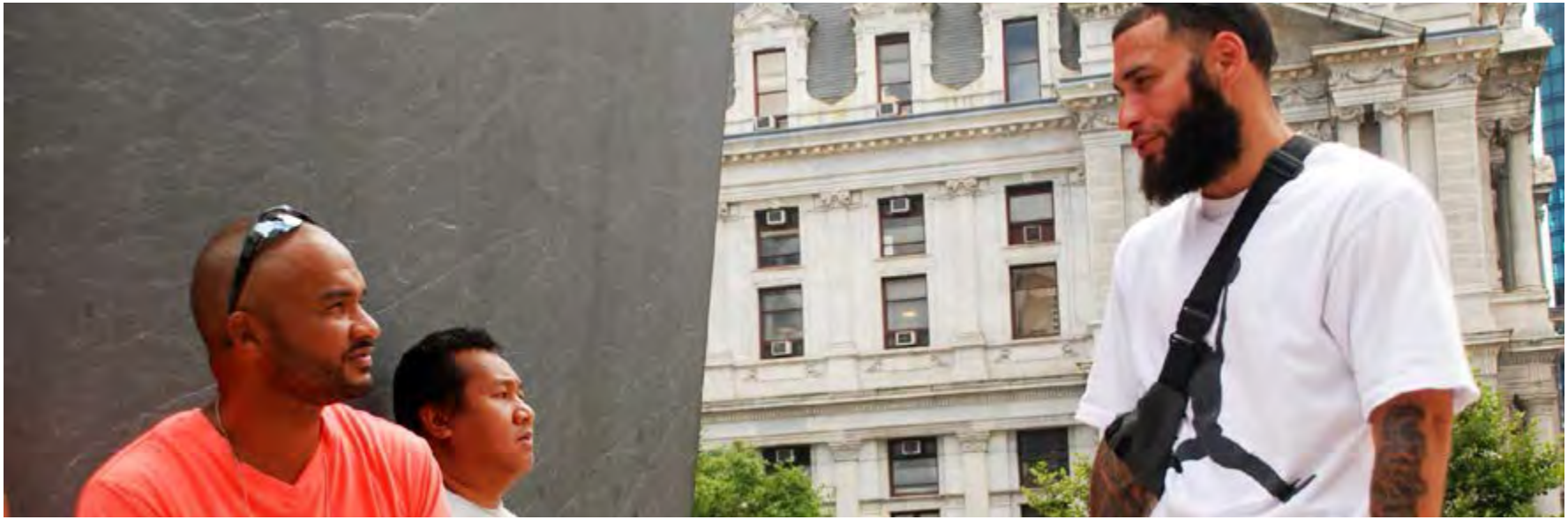
As people who have availed themselves of [behavioral] health services, [peer support staff] will share their own experiences and what skills, strengths, supports, and resources they use. As much as possible, [peer staff] will share their own recovery stories and will demonstrate how they have directed their own recovery processes.

EEOC guidelines allow employers to refer to psychiatric disability within a job description and posting if having had this particular life experience is considered to be related to an "essential function" of the job.

Transformation Center – Parts of a Job Description

Transformation Center – Sample Peer Staff Function and Responsibility Statements

Sample Job Description



Practice 4. Define Optimal Peer Staff Qualifications

Carefully consider your organizational culture and target population when defining optimal peer staff qualifications. Because peer staff ideally have experiences similar to those of people using your organization's services, be careful not to use these same experiences—or arbitrary thresholds regarding experience—to automatically disqualify candidates from hire.

Severity of Disorder

One of the most intensely debated issues related to peer roles is the nature or severity of the behavioral health condition that a person has to have in order to qualify as a "peer." It is not within the purview of the hiring team to determine the nature or severity of the person's behavioral health condition; to try do so is to confuse clinical status with job performance. The key issue that the hiring team will need to assess relative to the person's status as a "peer" is whether or not this person will be able to function as a credible role model and coach to the people he or she will be supporting. Has this person's life experiences with the behavioral health system and with other factors often associated with behavioral health conditions (such as poverty, unemployment, and discrimination) been sufficiently similar to those of the participants your agency serves? Will his or her recovery story speak to the participants he or she is trying to connect with? Can the person effectively leverage their recovery story to build rapport and promote hope? These are the issue that will most likely determine the person's effectiveness in the role of peer staff, rather than the particular diagnoses he or she received in the past.

> "We continue to be challenged by the issue of [length of] time in recovery. Some peers are participating in system transformation training and conferences while in treatment for substance use conditions, and this moves individuals into seeking peer support roles earlier in their recovery journey. Sometimes it works out well and sometimes it does not. We have found that emphasis should be placed on evaluating individual readiness to take on the emotional and professional aspects of the job when interviewing."
>
> Laura Boston-Jones
> CEO/Administrator
> Girard Medical Center

Abstinence

When it comes to peer support in addiction recovery, there are often questions about the minimum amount of time a person should be abstinent before working in the role. Here, too, the concern should be whether this person will be able to function as a credible role model and coach as well as perform the other functions of the job. Because substance use status is only one pane of the larger umbrella of recovery, it is important to consider the different domains of an individual's life in recovery when making this assessment.

Length of time abstinent does not necessarily equate to an increase in recovery capital and overall wellness. For instance, an individual with two years' abstinence could be more stable in terms of finances, housing, social supports, community belonging, and clarity of personal purpose than an individual with five years' abstinence. Therefore, it is important to assess candidates as individuals through a holistic lens that considers the whole of their recovery, as opposed to primarily assessing abstinence.

MAT

If your agency provides medication-assisted treatment services, to provide true peer support you'll likely want to consider hiring peer staff who have lived experience with using MAT as one of their recovery pathways.

Incarceration History

When you are interviewing a person for a Certified Peer Specialist position and their background check reveals charges and convictions, do not automatically dismiss this person even if the charges are serious. If the people you serve have histories of incarceration, they may relate well to a peer who also has that in his or her background. If the candidate seems qualified, meet with the person to discuss the situation further.

If hiring people with felonies is prohibited in your area, consider advocating to obtain waivers for peer support staff. In December 2015, Pennsylvania struck down a state law that forever barred people with felonies from working with vulnerable populations. According to Judge Mary Hannah Leavitt, providers "should not be required to employ a person with a criminal record, but they should have the opportunity to assess the situation and exercise their discretion to employ an applicant found to be sufficiently rehabilitated and a good fit for the job" (Langley, 2016).

The key issue that the hiring team will need to assess relative to the person's status as a "peer" is whether or not this person will be able to function as a credible role model and coach to the people he or she will be supporting.

> "The biggest struggle for folks is their criminal record; it holds them back. Those of us who have been reformed would be best for the position, but we do not get it because of our past. Now when I go to an interview, I bring a portfolio of my community work, where I have been highlighted in blogs, articles, newsletters, participated on panels, etc. I have done presentations with DBHIDS and have volunteered many hours. I bring all of this with me and present it with my criminal justice contacts to show where I was and who I am today."
>
> Peer Staff

Resources

Center for Behavioral Health Services and Criminal Justice Research Policy Brief

Resources for Human Development Media Release: "RHD joins lawsuit to overturn PA law that prevents hiring of people with criminal records"

Philly.com: "Adult care law limiting employment candidates"

Points to Consider When Interviewing a Person with a Legal Record

Practice 5. Include People Using Services on the Hiring Committee

"In the course of developing our Community Integration Recovery Center, Wedge integrated people receiving services into the interview process. These individuals were given a brief training in human resources policy and provided with sample interview questions and prohibited questions. People receiving services have been essential in supporting the selection of certified peer specialists who have been successful in their role."

Jason McLaughlin, Chief Operating Officer, Wedge Recovery Centers

People who have received services within your agency have an intimate understanding of the agency culture. By including peers on the selection committee, you are inviting a valuable perspective to the table. These individuals know some of the qualities or experiences that may be helpful for peer support staff to bring to the agency as well as some that may not beneficial. If your agency has a peer leadership body such as a Peer Advisory Council, this would be an ideal opportunity to integrate a couple of the members.

Numerous programs in Philadelphia include service recipients in the interview process for new peer staff. One such provider, Wedge Recovery Centers, has created guidelines with questions that people cannot ask a candidate on a job interview as well as questions that are appropriate to ask any job candidate. Providing this level of direction and support ensures that people receiving services can participate in the process in an active and meaningful way and also ensures that the process stays consistent with all legal requirements.

Wedge Recovery Centers – What Can You Ask?

Practice 6. Ensure that Hiring Staff Understand Relevant Employment Laws

What types of employment-related laws may be relevant as we hire people in recovery?

The *Rehabilitation Act of 1973* was the first "rights" legislation to prohibit discrimination against people with disabilities. The scope of this law, however, was limited to programs conducted or funded by Federal agencies. It did not extend protections to the private sector.

The *Family and Medical Leave Act of 1993* (FMLA) provides employees with up to 12 weeks of unpaid leave within a 12-month period, during which their jobs are protected. Job restoration is guaranteed unless the employee is unable to perform the essential functions of the job.

The employment provisions of the *Americans with Disabilities Act of 1990* prohibited discrimination against persons with disabilities in regard to job application procedures; the hiring, advancement, or discharge of employees; employee compensation; job training; and other terms, conditions, and privileges of employment. Title I of the ADA provides extensive guidance for organizations and employers regarding compliance expectations both pre- and post-hire.

Does the ADA apply to people with behavioral health conditions?

The ADA does not contain a list of covered conditions that constitute disabilities. Instead, the ADA has a general definition that each person must meet in order to be considered a "qualified individual with a disability." This definition focuses on whether the person is regarded as having physical or mental impairment that substantially limits one or more major life activities, or a record of such an impairment (EEOC, 1992). Therefore, some people with behavioral health conditions will have a disability that is covered under the ADA, and some will not.

The courts have been clear, however, that people with "current" substance use disorders involving illegal substances are not protected by the ADA. Anyone who has a positive drug test is considered under the law to be a current user, as are people who have been using within days or weeks prior to being discharged by their employers. Only a person in recovery from a substance use disorder who is not currently using substances may qualify as having a disability that may entitle that individual to reasonable accommodation. Such accommodations may include a modified work schedule to allow the employee to attend recovery meetings or granting a leave of absence for treatment.

People with alcohol use disorder may or may not qualify as having a disability, but even qualifying employees may be held to the same standard as other employees.

Should any employee qualify as having a substance-use related disability, he or she cannot be terminated for having the disability itself, but the law allows for terminating employees for misconduct stemming from the disability, such as driving while intoxicated.

Resource

U.S. Commission on Civil Rights: *Sharing the Dream: Is the ADA Accommodating All?*

Practice 7. Ensure that Hiring Staff Understand that Questions Related to Disability Cannot Be Asked During the Interview and Hiring Process

Title I of the Americans with Disabilities Act prohibits employers from asking disability-related questions at certain points in the employment process. Disability-related questions are those that are likely to elicit information about whether a candidate has a disability. The types of prohibited questions differ across the pre-offer, post-offer, and employment phases.

At the pre-offer stage, an employer *cannot* ask disability-related questions either directly or indirectly. For example, it is against the law to ask

"Do you have any physical or mental impairment that would keep you from performing the job you seek?"

"What medications are you currently taking?"

"How many days were you out sick last year?"

"When were you last in the hospital or in a detox program?"

These questions, asked directly or indirectly, would require an individual to disclose personal medical or disability-related information. These questions are prohibited to ensure that an applicant with a potential disability is not rejected before employers objectively evaluate the applicant's qualifications.

In addition, these questions are considered potentially discriminatory because they do not focus on whether the applicant can perform the essential functions of the job, with or without reasonable accommodations.

Given that potential employers cannot ask disability-related questions, some interviewers find it challenging to explore the person's recovery status and how that will impact their work. One point to remember is that one of the essential functions of the job for most peer staff is the ability to use their lived experience in recovery to support other people with mental health and substance use conditions. In this context, it is completely appropriate to ask questions such as, "In this role, how do you envision using your lived experience to support people with mental health and substance use conditions?"

In contrast to the pre-offer phase, once a conditional job offer has been made (and before an employee starts work), employers may ask disability-related questions and may also require medical examinations but *only if* such questions are job-related, consistent for business necessity, and required for all other entering employees in that same job category.

- **Interview Questions for Peer Positions**
- **Horizon House – Certified Peer Specialist Interview Questionnaire**
- **Comprehensive List of Sample Interview Questions**
- **Applicant Score Sheet**

Practice 8. Use a Range of Interview Formats

"Because employment law prohibits asking direct questions about a person's health status, we intentionally use a behavioral interviewing model. This is a structured and consistent interviewing technique that ensures a fair and unbiased process and ensures that we stay focused on whether or not the person has the right constellation of skills to be a good fit for our agency. We also utilize a pre-planned uniform written interview questionnaire to assess all candidates. This is an agency-wide practice across positions."

Jacqueline Blatt, Director, Horizon House
and Marcie Cole, Director, Horizon House

Tiered Screening and Interview Process

Agencies might consider starting the interview process with a screening call. This call would be designed to establish that the candidate meets some of the basic criteria for the position.

Candidates who cleared the initial screening would be invited to proceed to an individual or group interview. Group interviews in which the candidate is asked to discuss their reactions to a written scenario or role-play provide a glimpse into the person's ability to work as a team and build on the strengths of others. Do they dominate the conversation or listen, acknowledge positive comments that others may have made and then build on those? How effectively are they able to express an opposing viewpoint without criticizing others? How aware are they of their own beliefs, experiences, and biases and the ways in which their beliefs and experiences may influence their service provision?

Nontraditional Techniques

Peer staff have challenging roles within treatment organizations and need diverse skill sets. Increasing your staff's ability to identify candidates who will be a good fit will require strategies beyond the scope of a traditional interview. We recommend a mix of individual and group interviews and advocate the inclusion of case scenarios and role plays.

Core skills required of peer staff include intangibles that relate to their worldview, interpersonal style, and effective use of self. The presence of these attributes can be very difficult to ascertain in a traditional one-on-one interview. During the course of a more participatory interview, however, these characteristics are more likely to emerge and can be more fully assessed. Presenting brief participant scenarios and asking candidates structured questions will provide interviewers with more information about how the person will likely respond in real life situations. Similarly, role plays that ask a candidate to engage along side other candidates or staff demonstrate their ability to think on their feet and offer a glimpse into the person's interpersonal style.

Other core skills that should be assessed during the interview process are skills necessary for documentation and record keeping. As is the case with nearly any healthcare provider, peer support staff will be responsible for documenting

services provided and will often be doing so electronically. Although many candidates will understand that peer support work comes with this component, some may be considering only the soft skills required (such as the ability to engage and build rapport) and not necessarily the other skill sets needed to provide peer support. It is important to use the interview process to assess experience, comfort level, and attitudes around documentation and record keeping.

It is important for interviewers to have a shared vision of the skills and characteristics that peer staff will need to be successful in their unique organizational environment. Horizon House in Philadelphia, for example, identified the following characteristics as essential for their peer staff:

- Exhibit clear boundaries
- Are aware of their own strengths and challenges
- Present themselves in a professional manner through their attire, verbal, and nonverbal behavior
- Do not personalize an individual's comments
- Establish rapport with others
- Are organized and exhibit time management skills
- Exhibit a flexible attitude: if a situation arises, they are able to switch gears quickly
- Are adaptable to the work environment
- Have work or life experience with people in recovery from addiction or mental disorders or with homeless populations
- Can create and maintain good records

Horizon House – What Would You Do?

Horizon House – Role Plays

Screening Evaluation Tool

Practice 9. Hire More Than One Peer Staff

> "We always have five or six individuals volunteering at a time. We have found this approach to be beneficial to the organization and to the peers in that the peer volunteers are having a shared experience, as well as learning and processing with one another."
>
> Lisa Kramer, COMHAR

Philadelphia's providers, like many around the country who have integrated peer support staff, maintain that starting with at least two peer staff is critical. Although your ability to hire peer staff will be limited by available resources and projected income from their services, we strongly encourage you not to begin by hiring only one peer staff member. Doing so puts inordinate pressure on that individual to represent all peers. In addition, having only one peer staff makes it extremely difficult to identify the agency-level issues that inhibit their successful integration, as problems that arise are likely to be attributed to that individual rather than to the organizational culture. Most of the worst-case scenarios we have heard over the past 20 years have involved an agency hiring only one peer staff member as a first step. In many instances, that person was treated dismissively as a token, or quit or was terminated relatively quickly due to the feeling that he or she did not "fit in." It is extremely difficult for any employee to be the one and only of his or her "type" at a work site, whether that be determined by race, ethnicity, sexual orientation, cultural background, or disability status. Therefore it is best to begin by at least hiring two staff at the same time so that they can support each other and so that all staff will be better able to identify issues that require changes to the organizational culture or practices.

If your organization is unable to hire more than one peer staff member, another option to consider while you seek funding is hosting a peer support staff intern or volunteer. Across the country, peer support staff education increasingly requires practicums or internships in which trainees can apply the knowledge and skills acquired in the training classroom to real experiences. Hosting a peer support intern in conjunction with having a peer support staff member can be helpful if it is not feasible to have more than one paid peer support staff at your agency.

Another good practice is to make sure that peer staff have support beyond that provided by your organization. Peer staff may especially benefit from associations with recovery advocacy organizations that offer places for peers to access support for their own recovery.

> **"The more experience you get with the work, the more confident you are in the interview process and in answering questions because you have been there and done that."**
>
> *Peer Staff*

Practice 10. Identify an Executive Champion

While engaging recovery champions and influential staff will be crucial to your agency's implementation efforts, identifying an executive-level champion is of great importance. The leadership of any agency creates the vision, sets the tone, and ensures accountability at all levels of the agency. To those ends, an executive champion is needed to ignite and fan the flame of peer support integration. Also, for staff who may be slower to embrace the idea of peer support or may even be skeptical, executive champion involvement will signal the agency's commitment to peer support to all staff. Lastly, having an executive champion can be instrumental in securing staff access to the resources needed to remove barriers and overcome obstacles. Many providers find that some of their organizational policies and procedures hinder rather than facilitate the delivery of peer support services. For example, policies that prohibit staff from providing services outside of the office building, or that prevent staff from transporting people they serve in their personal or a company vehicle, can significantly impede the ability of peer staff to succeed at their jobs. Although supervisors can remove some of the barriers that peer staff face, in many instances, only executives have the authority to make the necessary policy and other organizational changes.

Ideally the executive champion would serve as the executive sponsor for the peer staff. Concretely, this would mean:

- Peer staff have direct access to the executive champion. They have open communication directly with their executive sponsor and are not forced to communicate up the chain of command.
- The executive champion understands and values the role of peer support services and is willing to advocate peer services at the executive level and in the broader system of care.
- The executive sponsor regularly meets with peer staff individually or as a group to identify organizational barriers and potential solutions for successful implementation. Regular meetings also to ensure that the peer staff members feel supported and have multiple venues for assertively addressing concerns.
- The executive sponsor is directly involved with tracking the impact of peer support services and leading the integration of any needed adjustments over time. This might involve reviewing evaluation data or participating in focus groups a few times a year with people receiving services.

This level of involvement may seem excessive. However, consider that regulations, policies, and fiscal strategies have evolved over many years to facilitate the work of traditional staff (psychologists, psychiatrists, case managers, social workers, psych technicians), whereas peer support staff do not typically benefit from, and at times are restricted by, longstanding structural supports. Without senior leaders directly involved in shepherding and championing the successful integration of peer staff, their tremendous potential will not be fully realized.

Practice 11. Offer Competitive Pay and Other Benefits

Peer support staff should be offered a competitive salary and the same opportunities as other staff for raises and promotions. When designing job descriptions and pay scales, ensure that the pay scale for peer positions is comparable to that of positions with similar qualifications. For example, if your qualifications and roles for peer staff are comparable to those of case managers, the salary ranges of the two positions should be similar. Looking at pay scales and job description of current staff can help you develop job descriptions that clearly differentiate the roles of peers and non-peer staff.

Also consider benefits such as a flexible work schedule. Many peer staff are scheduled to work 25–40 hours a week. However, the job often demands that peers work additional hours, often outside of normal business hours. The reality of peer support positions should be reflected in policies and procedures on overtime pay, flexible work hours, or flex time. Supervisors should be aware of work hours and demands on staff, while encouraging a work–life balance.

Practice 12. Ensure that Peer Staff Have Access to Resources

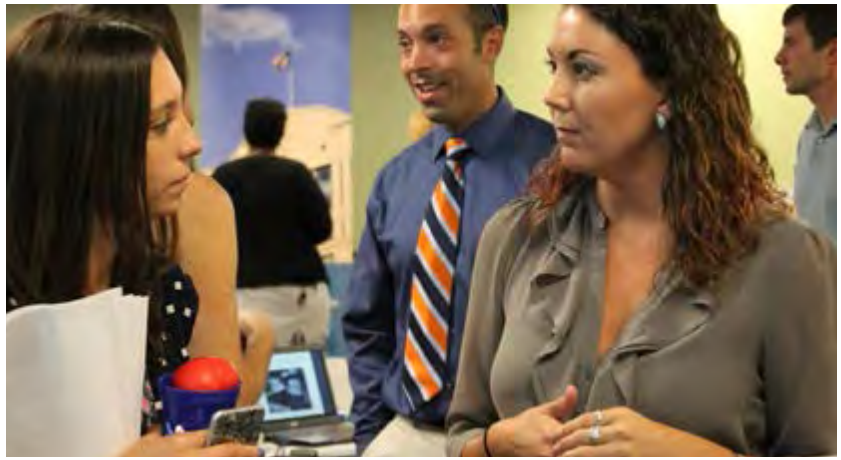
We know that "inadequate resources to meet work demands are likely to strain individuals' emotional resources, and, in turn, contribute to higher emotional exhaustion" (Laurence, Fried, and Slowic, 2013). It is important that peer staff have access to the array of resources and workspaces they need to be successful in their jobs and avoid burnout. The nature of services provided by peers already exposes them to high risk of burnout; taking measures to ensure that they are sufficiently supported in their workplace should be a top priority. This may include providing peer support staff with their own desk and private spaces to meet with individuals, as well as equal access to technology; transportation; knowledge of organizational resources available to staff; or additional staff support.

Ensuring peer staff have access to resources also means clearing their path of barriers to these resources. Barriers may include inordinate administrative or security processes or a lack of benefits available to other types of staff. For example:

- Peer staff members may have limited access to the transportation they need to spend regular amounts of time in the community and to provide transportation to participants. Access to a company van is often not an adequate solution, because multiple staff might have competing needs for the van.
- Peer staff often have limited access to petty cash, which limits their ability to address the emergency needs (e.g., clothing, food) of service participants.
- Peer empowerment may be restricted by layers of requirements and approval preventing staff from responding flexibly to needs as they arise.

Review policies and procedures that prevent or inhibit access to resources. You may want to form a task force with the active involvement of peer, clinical, supervisory, and finance staff charged with reviewing and revamping policies and procedures regarding the following:

- Reimbursement for mileage, with ride-sharing options for staff who do not have their own transportation
- Provision of meals and carfare vouchers to peers working at evening outreach events and community meetings
- Access to petty cash in emergency situations
- Communication and collaboration with allied systems and community-level sources of services and support
- Steps that peer staff are expected to take in responding to the needs of the individuals they serve



Peer Access Checklist Facilitator's Guide

Peer Access Checklist

Practice 13. Understand and Manage Accommodations for Employees with Disabilities

Although most employers are familiar with making accommodations for people with physical and sensory disabilities, many are less familiar with making accommodations for people with psychiatric disabilities. As peer staff become increasingly integrated into the workforce, more employers are requesting information and ideas on accommodations for employees with behavioral health conditions.

It is important not to assume that a person in recovery will require any modification or performance exemption simply because he or she has had a behavioral health condition. Similarly, if a performance issue should arise, employers should not assume it is related to the person's behavioral health condition. However, if an employee discloses that he or she has a disability (behavioral health or otherwise), and this disability is interfering with his or her ability to meet expectations, then he or she has the right to request "reasonable accommodation." A reasonable accommodation is any change in the work environment or in the way a job is performed that enables a person with a disability to have access to equal employment opportunities. The employee may make the accommodation request in "plain English," which might include language such as: "I have a medical condition that requires breaks every two hours…" or "Because of health issues, I need a quiet work space at the back of the office."

Common Questions About Managing Accommodations for Employees with Disabilities

The Office of Disability Employment Policy reminds employers that the process of developing and implementing accommodations should be individualized and should include the employee as a full participant in the process. Examples of potential accommodations that the Department of Labor suggests are outlined in the table below. Although the table does not include all possible accommodations, it provides organizations with ideas regarding effective and frequently used workplace accommodations.

> "Reasonable accommodations are adjustments to a work setting that make it possible for qualified employees with disabilities to perform the essential functions of their jobs. The majority of accommodations can be made for minimal (if any) cost and a small investment of time and planning. Moreover, effective accommodations can be good for business. They help employees return to work more quickly after disability or medical leave, eliminate costs due to lost productivity and can be key to recruiting and retaining qualified employees."
>
> United States Department of Labor, Office of Disability Employment Policy

Examples of Accommodations for Employees with Psychiatric-Related Disabilities

Accommodation	Examples
Flexible Workplace	Telecommuting and/or working from home
Scheduling	Part-time work hours, job sharing, adjustments to the start or end of work hours, compensation time or "make up" of missed time.
Leave	Sick leave for reasons related to mental health, flexible use of vacation time, additional unpaid or administrative leave for treatment or recovery, leaves of absence and/or use of occasional leave (a few hours at a time) for therapy and other related appointments.
Breaks	Breaks according to individual need rather than a fixed schedule, more frequent breaks or greater flexibility in scheduling breaks, provision of backup coverage during breaks, and telephone breaks during work hours to call professionals and others needed for support.
Other Policies	Beverages or food permitted at workstations, if necessary, to mitigate the side effects of medications; on-site job coaches.
Modifications	• Reduction or removal of distractions in the work area • Addition of room dividers, partitions, or other soundproofing or visual barriers between workspaces to reduce noise or visual distractions • Private offices or private space enclosures • Office or work space location away from noisy machinery • Reduction of workplace noise that can be adjusted (such as telephone volume) • Increased natural lighting or full spectrum lighting • Music (with headset) to block out distractions
Equipment/Technology	• Tape recorders for recording or reviewing meetings and training sessions • "White noise" or environmental sound machines • Handheld electronic organizers, software calendars, and organizer programs • Remote job coaching, laptop computers, personal digital assistants and office computer access via remote locations • Software that minimizes computerized distractions such as pop-up screens
Job Duties	• Modification or removal of non-essential job duties or restructuring of the job to include only the essential job functions • Division of large assignments into smaller tasks and goals • Additional assistance and/or time for orientation activities, training and learning job tasks and new responsibilities • Additional training or modified training materials

Continued

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Accommodation	Examples
Management/ Supervision	• Implementation of flexible and supportive supervision style; positive reinforcement and feedback; adjustments in level of supervision or structure, such as more frequent meetings to help prioritize tasks; and open communication with supervisors regarding performance and work expectations • Additional forms of communication or written and visual tools, including communication of assignments and instructions in the employee's preferred learning style (written, oral, e-mail, demonstration); creation and implementation of written tools such as daily "to-do" lists, step-by-step checklists, written (in addition to verbal) instructions and typed minutes of meetings • Regularly scheduled meetings (weekly or monthly) with employees to discuss workplace issues and productivity, including annual discussions as part of performance appraisals to assess abilities and discuss promotional opportunities • Development of strategies to deal with problems before they arise • Written work agreements that include any agreed upon accommodations, long-term and short-term goals, expectations of responsibilities, and consequences of not meeting performance standards • Education of all employees about their right to accommodations • Relevant training for all employees, including co-workers and supervisory staff

Source: United States Department of Labor, Office of Disability Employment Policy, 2016.

Resources

The Job Accommodation Network (JAN) is a free consulting service from the U.S. Department of Labor's Office of Disability Employment Policy that provides individualized accommodation solutions and information on the ADA and services related to employment for people with disabilities. JAN can be accessed at 1-800-526-7234 (V/TTY).

The Center for Psychiatric Rehabilitation's Reasonable Accommodations for People with Psychiatric Disabilities: An Online Resource for Employers and Educators includes specific tips for employers on developing and implementing accommodations.

Ten regional Disability and Business Technical Assistance Centers (DBTACs), sponsored by the U.S. Department of Education's National Institute on Disability and Rehabilitation Research, provide ADA information, training and technical assistance across the nation. They can be contacted at 1-800-949-4232 (V/TTY).

The Equal Employment Opportunity Commission's Enforcement Guidance on the ADA and Psychiatric Disabilities answers some of the most common questions about the ADA and persons with psychiatric disabilities.

Practice 14. Support Successful Candidates in Navigating Issues Related to Entitlements and Health Insurance

During the hiring process, individuals considering work as a peer support may have questions about how the income and change in job status may impact benefits they currently receive, including their health care and disability insurance such as Social Security. Although it is not incumbent on the hiring committee to raise these issues, it is important that you can point the new employee to information and perhaps guidance on navigating these systems. Especially with respect to disability-based income (e.g., SSDI), there have been many changes made in the last decade to decrease the disincentives that discouraged people from returning to work once they were determined to be disabled. In Pennsylvania in particular, it is important to be aware of the provisions of the Ticket to Work program.

Ideally, peer staff should be advised to consult with a benefits coordinator so that they can make informed decisions about the optimum number of hours to work and ensure that they have a livable wage and benefits.

Practice 15. Create a Positive Onboarding Experience

> **"I found out that I did not know office protocols and my usual idealistic approach caused some bumps and scraps along the way. Peer support staff need to be taught office protocols and this will save everyone conflict and stress."**
>
> *Peer Staff*

Once hired, what training will new peer staff receive both as part of new employee orientation and specific to their new role? It may be beneficial to begin this discussion during the interview process, as the dialogue may give you a sense of the person's previous experiences and confidence level, as well as provide an opportunity for candidates to consider areas where they may need additional training and support. After hiring, re-visiting which aspects of the job the applicant is most comfortable with and which may require training or support can be a very useful process for both parties and guide your immediate next steps related to training and supervision.

During orientation, it will be important to expose new peers to as many facets of the organization as possible. In the initial days of employment, they may benefit from shadowing other members of their team to better understand their work context, their role and the roles of others, and opportunities for collaboration.

Depending on the person and the job, some peer applicants will have had extensive pre-service training, including certification, while others may have had very little, if any. It is important to remember the significant diversity that exists in terms of previous employment experience. For some peers, this may be their first experience working in an office setting or a professional environment, while others may have had years of experience in similar environments. Take care not to assume the existence of skills around the use of the photocopier, telephone system, and other office equipment. Instead, include introductions to and instructions around the use of office equipment as part of the orientation process.

One frequently overlooked but critically important part of the onboarding process is announcing the presence of new staff members to the organization. Many organizations routinely send out organization-wide announcements welcoming new staff. Others are not as consistent regarding this practice. Particularly for this role, sending an announcement reinforces leadership's commitment to moving the organization toward a recovery-oriented service approach, clarifies the peer support role for existing staff, and set expectations regarding teamwork and collaboration. Without such an announcement, the introduction of new peer staff can be marred with tension as staff are left to wonder who the new person is, what exactly he or she will be doing, and whether or not it will negatively affect them.

Sample New Hire Announcement

Effective Service Delivery

Effective Service Delivery: What, Why and How?

Promising Practices:

Initial Engagement

- P1. Conduct Assertive Outreach Before Treatment
- P2. Utilize Peers to Create a Welcoming Environment
- P3. Promote Hope, Build Rapport, and Establish Trust
- P4. Create Safety
- P5. Train Peer Staff to Demonstrate Their Value

Conducting Assessments and Facilitating Recovery/Wellness Planning

- P6. Integrate Peer Staff Into Assessment and Service Planning Processes
- P7. Ensure Your Assessment Tools and Processes Are Recovery Oriented
- P8. Ensure that Wellness/Recovery Planning Processes Are Individualized and Person-Centered

Designing Your Approach to Delivering Peer Support Services

- P9. Provide Short- and Long-term Peer Support Services
- P10. Support Multiple Pathways to Recovery
- P11. Create and Offer a Menu of Options

Creating a Culture of Peer Support

- P12. Promote a Culture of Peer Leadership and Support
- P13. Develop a Peer Advisory Council

Promoting Community-Integration

- P14. Ensure that Peer Staff Understand Their Role in Promoting Community Integration
- P15. Assertively Develop Partnerships with Other Community Organizations

Continuing Support

- P16. Provide Assertive, Responsive Continuing Support
- P17. Intensify Support During Times of Vulnerability
- P18. Offer Telephonic Support for Addiction Recovery

module 3

Effective Service Delivery: What, Why and How?

Peer support staff, properly trained and utilized, can be key to implementing recovery-oriented screening, assessment, service planning, and service delivery. By definition, recovery-oriented approaches entail the empowerment and active participation of those seeking services. Although all program staff are responsible for respectful interactions with those they serve, peer staff—by virtue of their openly acknowledged past experiences as service users themselves—are in a unique position from which to build trust, inspire hope, and encourage self-determination. This module shares practices that can help peer staff in your organization provide effective person-centered services, from pre-treatment outreach through post-treatment support.

Practice 1. Conduct Assertive Outreach Before Treatment

At some point in their lives, almost half of U.S. adults will experience a major mental illness, and at any given time frame, nearly one in five will have a serious mental illness (Price, Khubchandani, Price, Whaley, & Bowman, 2016). About half of those who will develop a mental health condition show symptoms by age 14 (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Effective treatments exist, but for numerous reasons, many people do not seek services until long after the first onset of symptoms. The same pattern of delayed help seeking is also true for those with substance use disorders. On average, most people in specialty treatment have lived with the substance use disorder for 10 years before seeking treatment (Hasin, Stinson, Ogburn, & Grant, 2007). When people seek treatment at later stages, their conditions have often become more complex, and the toll on their lives more devastating. Assertive outreach addresses many barriers that keep people from entering, engaging in, or remaining in behavioral health services. Given the tendency of untreated behavioral health conditions to grow more serious over time, early intervention can dramatically influence the course of behavioral health conditions.

Peer staff play a key role in promoting detection and early intervention. Assertive outreach activities include the following:

- Using a team approach to conduct street outreach to areas of the community where people who are most vulnerable tend to congregate.
- Providing community education and social marketing aimed at
  - reducing the stigma attached to seeking treatment.
  - promoting the reality and hope of recovery and wellness through sharing the lived experiences of people in recovery.
- Involving peer staff in developing Memoranda of Agreement and strategic partnerships with organizations and natural supports in the community (e.g., faith communities, barbershops and beauty salons, culture-specific organizations) that also interact with people who may need behavioral health services.
- Collaborating with regional or state partners to offer mental health first aid training to build community skills in identifying and responding effectively to people with behavioral health challenges.
- Conducting outreach in non-stigmatized service settings (e.g., mainstream health care, culture-specific healing and health promotion settings, elementary schools, high schools and community colleges, public libraries, recreation centers).

Rather than waiting for people to "get ready" and present for treatment, peers can help people identify their need for services, resolve ambivalence about receiving services, and strengthen their motivation for change. When the demand for treatment exceeds availability, individuals are often placed on waiting lists, during which time dropout rates may be as high as 25–50 percent (Little Hoover Commission, 2003; Donovan, Rosengren, Downey, Cox, & Sloan, 2001). Before treatment begins, peer staff can conduct "recovery priming" activities that increase a person's hope, motivation, and successful engagement:

- Reach out to individuals on waiting lists and invite them to participate in pre-treatment peer support groups.
- Provide other interim services to people on waiting lists, including conducting initial needs assessments and identifying ways of meeting immediate basic needs.
- Ask people on waiting lists for permission to provide regular telephone check-ups, (see recommendation 19 on Telephonic Recovery Support).
- Offer to meet people in person to orient them to the treatment process.
- Engage people in recreational opportunities to meet and connect with other people in recovery, to increase their motivation, hope and sense of connectedness.

Resources

Mental Health First Aid

DBHIDS Healthy Minds

Practice 2. Utilize Peers to Create a Welcoming Environment

Reception and clinical staff may not always have the time to engage with individuals in the waiting room or to orient them to the treatment process before the initial intake/assessment process begins. But these are exactly the kinds of things that a peer support staff person can do to build rapport with individuals and create a comfortable and inviting initial experience for them.

The Role of Peer Greeters

Whether it is a paid peer support staff member, a Peer Advisory Council member, or a peer volunteer, having a peer welcome someone at the front door when he or she first arrives for help could be the one factor that keeps the individual seeking help engaged. When peers are in this role, they may be the first faces individuals seeking help will see. Peers provide a warm smile, a glimmer of hope, and a hand to walk through what can be an intimidating process. Many Philadelphia providers found that people are more likely to complete the intake/assessment process and return for services when greeted by a peer.

The Role of Peer Mentors

In the past, several of Philadelphia's treatment providers had instituted a buddy system in which an individual who was new to treatment was matched with an individual who had been receiving services and could assist with orientation and help the new person build connections. Today this practice is evolving into a more structured approach. Peer Mentors are often interested in providing peer support. They should receive some basic training—such as motivational interviewing, storytelling, and Mental Health First Aid—to increase their effectiveness in their roles. With training and support, mentors can take on new roles in addition to their traditional role of welcoming new people, such as

- becoming members and leaders of a Peer Advisory Council;
- presenting and sharing their personal stories of hope and recovery both within the agency and in the broader community;
- conducting telephonic outreach: reminder calls and outreach calls for missed appointments (with consent first provided by the people receiving services); and
- co-facilitating peer-run support and educational groups.

> "Resource Centers are an entry point into recovery and a way to stay connected to recovery through and following the treatment process."
>
> The Net Consumer Council, A.C. Evans, R.C. Lamb, S. Mendelovich, C.J. Schultz, & W.L. White, *The Role of Clients in a Recovery Oriented System of Addiction Treatment: The Birth and Evolution of the NET Consumer Council*, 2007, p. 7.

The Role of Recovery Resource Centers

Peer-run centers provide a welcoming and safe environment where peers can go before, during, and after treatment for social activities, mutual support, basic needs, and resources. Some of the resources may include assertive linkages to community connections, housing support, assistance with medical treatment and supports, clothing, food, employment supports and opportunities, life skills, and a computer lab. In some of Philadelphia's organizations, the recovery resource center has become a central hub for people to give and receive support to one another.

Resource centers are evolving to provide far more than support and socialization. Peer staff have been central to establishing the infrastructure, the vision, and the resources to ensure that recovery resource centers provide the tools and connections that people need in order to take action toward their personal goals. Resource centers also provide a safe haven in which a recovery culture can grow and thrive.

Practice 3. Promote Hope, Build Rapport, and Establish Trust

In the past, many mental health services virtually ignored the need for hope. Some services were designed to promote little more than the successful management of chronic conditions, which—it was commonly assumed—would forever limit the lives and choices of people with behavioral health conditions. Today, the effective peer support provider is an advocate for hope; he or she is living evidence that recovery is real and worth the effort. The story of the peer staff's journey toward wellness and recovery is a story of hope.

In many instances, peer staff find that the individuals they are supporting do not initially hold significant hope for leading a meaningful life in their community. Numerous factors might contribute to this. They may be drawing on most of their mental and emotional resources to deal with difficult life circumstances or challenging behavioral health symptoms. They may have experienced multiple unhelpful encounters with behavioral health providers in the past. They may have been struggling for so long that they no longer believe their life can be different. They may have never witnessed or recognized recovery in the life of somebody they know. Whatever the reason, one of the peer provider's critical tasks in the initial engagement process is to promote hope. Peer staff can effectively strike a balance between responding with compassion to the very real challenges that people have experienced and also encouraging them to envision and move toward a different future for themselves.

Explore Strengths

Peer staff can help instill hope by working with people to explore strengths and successes. During initial discussions, peer staff could ask:

- Have you experienced a time when you were able to sustain your recovery or sense of wellness for a day? What worked?
- What are you good at? What have you been good at in the past?
- Suppose tonight, while you slept, a miracle occurred. When you awake tomorrow, what would be some of the things you would notice that would tell you life had suddenly gotten better? (de Shazer, 2000)
- How have you survived the things that have happened in your life? What strengths have kept you going?
- How would you like the services I'm offering to be different from services you've received in the past?

Share Recovery Journey

Peer staff may also promote hope by sharing elements of their lived experience with those they are supporting. Sharing one's story of recovery often dissolves stigma, shame, and isolation, and can be very powerful if done strategically.

To be effective, peer staff should be

- clear about the specific purpose for sharing their lived experience.
- skilled at intentionally highlighting aspects of their story that may be relevant to the person they are working with.
- equipped to share enough of their personal challenges so that they are relatable without glorifying the difficult times.
- aware that although they may share similar lived experiences with the person they are supporting, each individual is unique and no two experiences are exactly the same.
- able to balance the need to normalize common experiences of behavioral health conditions without overwhelming people on emotional levels or making their own challenges the focus of the conversation.
- able to demonstrate that a personal practice of recovery can change a person's life.

Increase Community Capacity for Storytelling

Peer staff can also play an important role in equipping others with the skills and opportunities to share their stories. The Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) hosts free, peer-run recovery- and resilience-based Storytelling Training for peer staff, adult family members, and others. Creating a culture in which stories of recovery are frequently revisited has been a powerful catalyst for systemic, organizational, and individual transformation in Philadelphia.

Other critical tasks during the initial engagement process include establishing rapport and building trust with people who are seeking or who are in need of services. It is essential that each peer staff provider cultivates his or her unique friendly, welcoming, and respectful way of approaching people that conveys an attitude of understanding, openness, and acceptance of others, regardless of their life circumstances.

DBHIDS Storytelling Framework

DBHIDS Storytelling Tips

Resources

Additional Details for Using and Further Exploring Responses to the Miracle Question

Practice 4. Create Safety

It is essential that peer staff keep in mind that anyone they serve—however "put together" that person might seem—may be experiencing the effects of toxic stress or trauma. A history of trauma is common in the general population and even more common among people with behavioral health conditions. Similarly, toxic stress—chronic exposure to economic, social, environmental, or health-related stress (e.g., poverty, racism, social isolation, chronic illness)—is common in communities served by public treatment systems.

It is important that peer support staff work to understand each individual's behaviors in the context of these experiences. What may appear to be denial, resistance, non-compliance, manipulation, "acting out"—or even using alcohol or drugs—might actually be the most effective skills people know for tolerating pain and protecting their sense of safety. This can be true even if these skills repeatedly introduce more pain and danger.

Particularly in the realm of addiction recovery, some treatment providers and recovery groups have old traditions of "breaking down" an individual's psychological defenses with harsh words. For some individuals, however, those traditions can be disruptive to recovery. Only when people learn healthier skills for self-protection are they able to let go of the old, counterproductive responses. Effective treatment and peer support approaches are rooted in safety, respect, compassion, acceptance, self-care, empathy, and a willingness to find people's strengths and help them build new skills.

All treatment organizations have a number of responsibilities in this area. Responsibilities include the following:

- Providing peer staff with training on trauma-informed peer support services to ensure they learn about resilience, toxic stress, and trauma; the many ways these experiences might affect people; and their implications for health. *The Power and Price of Survival* is one resource that helps people to understand how the body reacts to intense or long-term stress, threat, or trauma. Resources such as this can help peer staff understand that some of the behaviors they witness are not because people are "acting out," but instead are linked to physiological responses to chronic stress and trauma. This understanding can help them to be more empathic and helpful.
- Ensuring that peer staff know how to avoid saying or doing anything that might re-traumatize people or trigger symptoms of preexisting trauma.
- Ensuring that peer staff are able to identify situations in which individuals might need to be referred for stabilization or trauma-specific treatment.
- Teaching peer staff the signs that people exhibit when reminders of past trauma have "triggered" them, how to use grounding techniques to help people return to the "here and now," and the resources they can call on immediately, if need be, to help individuals stabilize.
- Supporting peer staff in exercising and modeling healthy self-care and appropriate boundaries in their interactions with the people they serve.
- Setting the expectation and providing the necessary support for peer staff to work with individuals to identify and address any current sources of danger in their lives.

Of course, safety is not only a psychological issue. There are many dangers within communities, and the people that we serve and peer support providers are all vulnerable to some of these dangers. Peer staff are encouraged to take the following actions:

- Look for safety issues in the lives of the people they serve (e.g., family violence, community violence, unsafe relationships, unprotected sex, bullying, the need to cross gang lines, and safety issues within the treatment setting), and work with their supervisor to identify safety measures that can reduce people's risk.
- Study the challenges to their own safety that they might encounter in the communities and families they serve, and make a safety plan with the agency that might include working in teams of two, making sure they have safe and ready transportation, always carrying cell phones, establishing periodic phone check-in times, finding safe locations to meet with people they are serving within the community, learning self-defense skills and strategies, etc.
- Become familiar with safety resources in the community, including law enforcement, public safety, domestic violence agencies, community watch groups, anger management classes, violence intervention programs, and the like.

Tips for Creating Safety

Grounding Exercise Facilitator's Guide

Grounding Exercise Script

P. Woll (2011), *The Power and Price of Survival*

Practice 5. Train Peer Staff to Demonstrate Their Value

Many people have positive experiences in treatment, but others are skeptical or cautious about engaging in services. Their hesitancy about accessing services may include the services offered by peer staff working in treatment settings, who are viewed as an extension of the treatment program. Many people do not initially understand how the roles of peer staff differ from those of clinical staff, especially if peer services are a new offering for your organization. To establish credibility and build rapport, peer staff should help clarify their role and demonstrate their value to individuals seeking services.

The box below contains some questions that peer staff can use to begin demonstrating their value. These questions can assist peer providers in identifying and responding to the immediate needs and interests of the individuals they work with.

Peer support provider: **"What's most important to you right now/today?"**

Person supported: **"My recovery"/"My health."**

Peer support provider: **"What does that mean to you?"**

"Tell me more."

"How would you like things to be different?"

"What would you say are the biggest challenges you're facing right now?"

"If there were one thing you could change right now, what would it be?"

"How can our team help you?"

"What are one or two things we could start by helping you with today or this week?"

Once individuals have articulated their needs, it is critically important that peer staff have the resources, connections, and ability to respond. Organizational policies can hinder or facilitate response. For example:

- Does your organizations have resources set aside for bus/train passes, emergency shelter, meals? If so, do peer staff have immediate access to these resources, or do they need to navigate multiple approval processes to secure a bus pass for a person?
- Do peer staff consistently have access to needed resources, or does their access depend on the availability of one staff person?
- Does the organization have current partnerships with other organizations that meet typical needs, such as childcare facilities, housing resources, and employment supports?

See Module 2 Practice 12 for more information on providing resources for peer staff.

Practice 6. Integrate Peer Staff Into Assessment and Service Planning Processes

> **"The therapist and I work well together. The therapist provides the individual therapy, and if somebody needs help with things like housing, a community resource, a food bank, renewing a driver's license or accessing public transportation, we have an electronic referral system and I get an alert so I can provide that support."**
>
> *Peer Staff*

Depending on the organizational context, peer staff will have varying opportunities to collaborate with clinical staff in the assessment and service planning processes. In some instances, when people indicate the desire to work with a peer provider at the outset of the treatment process, clinical and peer support staff have an opportunity to conduct the assessment together. In other instances, persons may not be referred for peer support services until a later point in their treatment episode, at which point their clinician has already conducted their initial assessment. In either case, peer staff should also perform an assessment with the individuals they are supporting. Done correctly, this process accomplishes several things at once:

- It further develops and strengthens the peer support relationship.
- It awakens or reinforces a sense of hope and possibility.
- It informs the wellness planning process and the focus of future peer support services.
- It gives people concrete documentation of a desired future state and the strengths that can help them reach that state.

Although it is not always feasible for peer and clinical staff to participate in assessment processes together, in organizations that view peer staff as integral to the service team, peer-based assessment and wellness planning processes are coordinated or integrated with assessment and planning processes on the treatment side.

The following strategies can help to promote coordinated approaches to assessment and service planning in treatment settings.

- Coordination among peer, intake, and clinical staff prior to intake can ensure that peer staff are introduced as part of the service team during intake interviews. Peer staff may need to be present in the waiting room and at intakes on a rotating schedule, so someone is always available to greet people and participate in initial assessments, as appropriate. At the very least, covering the waiting room and intakes will give peer staff opportunities to connect with people seeking services, describe their roles, and offer support.
- When feasible, peer and clinical staff may conduct all or part of the service assessment process together. For example, the Recovery Capital Scale has important content for counselors. Many items assessed in clinical processes also have important implications for peer support services, and some people accessing services might be more comfortable if a peer is involved in the clinical assessment process.
- If peer staff conduct separate assessment processes:
  - Peer staff should share assessment information with the clinical team to inform individualized treatment planning.
  - They should hold a three-way meeting with the clinician and the person receiving services to share implications of the assessment and to use the assessment results in a process that helps the individual identify his or her priorities. During these collaborative team meetings, it is important that the person being served is always empowered to direct the process.
- Peer and clinical staff should periodically meet with the individual to revisit and update the assessment and review and adjust goals and priorities.
- Utilization review meetings and other staff meetings should include peer staff and give them meaningful opportunities to share their observations.

An assessment process can enhance the staff member's connection with the individual served or increase the distance between them. Although tools and questions are important, the most important consideration is the process itself and the effects it has on the service relationship. To that end, it is important to ensure that the assessment process is experienced by the people receiving services as a natural conversation and that it is friendly, strength-based, and collaborative.

"The thing about peer specialists compared to professionals is that we know how to get things done and we make their jobs easier. Therapist will call us to do presentations, to find clothing or other basic needs, etc. We work well together and make a great team."

Peer Staff

Practice 7. Ensure Your Assessment Tools and Processes Are Recovery Oriented

Regardless of whether it is performed by clinical or peer staff, a recovery-oriented assessment process differs from conventional assessment approaches in several ways (White, 2008). Recovery-oriented assessments

- are holistic in that they equally explore needs across multiple life domains rather than primarily examining the circumstances and symptoms related to the behavioral health condition.
- examine the desired future state as well as the past and current realities.
- focus on strengths and assets rather than problems and deficits.
- contain questions about the individual, family, and the surrounding community, rather than just about the individual.
- are periodic, rather than a one-time assessment that occurs at intake.

Holistic

A holistic assessment and service planning process reflects an understanding that health is more than just the absence of symptoms. People are far more than their identified behavioral health challenges, and all life domains are connected. Merely persuading someone to take medications, refrain from using drugs, or use more effective cognitive restructuring strategies will not solve the essential problem if elements of the individual's life are unsafe, deeply unsatisfying, or difficult to endure.

For peer staff to maximize their impact in people's lives, their assessment processes need to explore various life domains. Common domains include the following:

- Recovery or wellness
- Housing
- Living independence
- Financial independence and solvency
- Employment and education
- Relationships and social support
- Medical health
- Leisure and recreation
- Independence from legal problems and institutions
- Mental wellness and spirituality

Focused on the Desired Future State

One of the key differences between a traditional clinical assessment instrument and a recovery-oriented one that a peer provider might use is that traditional instruments focus primarily on the past and current state, whereas recovery-oriented instruments also have questions that help the person to re-imagine and explore his or her desired future state. Here are a few sample questions in two of the many possible life domains:

In housing

- Where do you currently live?
- Is there anything about your living situation that worries you right now?
- Do you feel safe and secure in your home? In your neighborhood?
- Are you interested in living somewhere else in the future?
- How would you most like to live in the future: Independently? With support? With other people?

In employment and education

- Are you currently employed? If so, can you share where and what you are currently doing?
- Are you happy with your current job? If not, what would you like to be different?
- What is your ideal job?
- Are you interested in getting a job now?
- What kind of support do you think you might need to get back to work?
- How far did you get in school?
- Are you interested in going back to school?
- Do you have any specialized training?

The assessment is far more than an inventory of a person's current life circumstances. With the right questions and process, assessments represent an opportunity to reawaken hope.

Focused on Strengths and Assets

Given the stigma associated with behavioral health conditions, many people enter services with a deep sense of shame regarding their illnesses, symptoms, and experiences. For some, their sense of shame has become a source of added vulnerability. It might leave them isolated, or feeling more guarded or passive. Or they might hide it under defiance or bravado or withhold important information from providers to try to "save face." If assessment tools and processes begin by inquiring about problems, or place their central focus on pathologies, this can reinforce people's sense of shame, potentially skewing the information gathered and compromising the possibility of a meaningful service relationship.

Strength-based assessment processes can have the opposite effect. They can bolster the hopes that have been diminished by illness and restore the sense of dignity that leads to honest self-disclosure and interpersonal trust. These processes require a central focus on an individual's strengths, resources, and recovery capital (the internal and external resources people can call on to begin and sustain recovery) (Granfield & Cloud, 1999). Strategies that can help to facilitate this include the following:

- Assume that people have strengths in each life domain, and ask your questions in ways that make this clear. For example, instead of asking "Do you have any talents?" ask, "How would you describe your strongest talents?"
- When people have difficulty identifying strengths, help them to examine and reframe their past (e.g., a history of survival and resilience in the face of challenges, values instilled in childhood), the present (e.g., skills, ingenuity in difficult circumstances, sense of humor, elements of positive self-care), and the future (e.g., hopes and dreams for a better life).
- Incorporate assessment tools such as the Recovery Capital Scale that explore family, environmental, and community assets.
- Ask strength-assessment questions first—or preceding these tools with a comprehensive strength inventory, if you are required to use a particular tool that starts with problems.

Focused on the Individual, Family and Community

There is mounting evidence that social and environmental factors account for a greater proportion of health outcomes than healthcare services or the specific treatment approach used. There are increasing calls to expand the unit of service beyond the individuals that we typically work with and to also view their families and communities as targets for intervention. Recovery-oriented assessments examine the strengths and vulnerabilities of individuals, families, and their surrounding communities.

The Recovery Capital Scale can be used to begin the exploration of people's assets and vulnerabilities.

Recovery Capital Scale

Guidelines for Developing a Strength-Based Assessment

Practice 8. Ensure that Wellness/ Recovery Planning Processes Are Individualized and Person-Centered

Recovery and wellness plans integrate all of the information that people have shared during the assessment about the lives, their strengths, and their challenges into a document that helps to guide the focus of the collaboration between peer providers and the people that they serve.

Historically, treatment planning often provided a generic list of service goals, which people were then required to meet. These "one-size-fits-all" approaches resulted in plans that often did not feel relevant and meaningful for the people they were designed for. These planning processes were also directed by clinicians, but experience has taught us that planning must be a collaborative process, driven by the individual rather than by service providers. In recent years, recovery is often explicitly defined to include a person-driven approach: "Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) toward those goals" (SAMHSA, 2012).

For a wellness plan to be considered person-centered, according to Tondora, Miller and Davidson (2012), it should

1. be oriented toward promoting recovery rather than only minimizing illness;
2. be based on the person's own goals and aspirations;
3. articulate the person's own role and the role of both paid and natural supports in assisting the person to achieve his or her own goals;
4. focus and build on the person's capacities, strengths, and interests;
5. emphasize the use of natural community settings rather than segregated program settings; and
6. allow for uncertainty, setbacks, and disagreements as inevitable steps on the path to greater self-determination.

When conducting wellness-planning, remember that people are the experts on their own lives, goals, and planning processes, and peer staff are consultants brought in to help them reach their goals.

Wellness/recovery plans are not only helpful for the people being served, they are also helpful for peer staff. A recovery plan helps peer staff keep services focused on the areas that individuals identified as most important to them and that help people move towards their larger life goals. Although urgent needs may arise, a wellness/recovery plan ensures larger life goals stay in focus.

At the center of the plan are the life goals that the individual chooses. These are not service or programmatic goals such as "take my medication," "complete the program," "attend three groups each week, "stop using alcohol." Instead, these are goals that are personally important to the person. Often when asked about goals, people will respond with a more service-oriented goal. In these instances, peer staff should explore what is underneath that goal. The key question in these situations is "Why?" "Why is it important for you to stop using alcohol or to attend group, or to complete this program?" In response to that question, people will typically share a life goal that can focus the collaboration between the peer provider and the person being served. They might share for, example, that they want to

- live independently.
- improve their education or employment to have a better quality of life.
- have better housing.
- become a better parent, spouse, etc.
- get their children back.
- open their own bank account.
- be reunited with their family.
- be able to take care of their children.

The assessment process is directly connected to the wellness/recovering planning process, which is why asking future-oriented questions during assessment is so important. During the course of the assessment, individuals often identify several aspects of their life that they would like to enhance. Peer providers play a critical role in helping people to prioritize what is most important to them in the short-term and determining which areas are most amenable to change based on their unique resources, strengths, and key relationships. These will be the areas to focus in on most immediately. Peer staff want to help set people up for a sense of achievement and success. This starts by looking for the short-term wins that can be more easily attained.

One of the keys to an effective planning process is to keep it as simple and manageable as possible. If people prioritize one or two areas that they would like to focus on, then the next step is to support them in identifying one or two actions that they can take with support in the very near future. Strengths, challenges, and resources may also be factored in. A wellness/recovery plan is a living document. It is not designed to be completed and filed away, but rather to function as a road map for action. It is one of the most powerful tools that a peer provider can use to support people in reaching their wellness goals and transforming their lives.

Many people that peer staff serve, however, will be accustomed to a traditional and narrow service planning approach in which they are a passive participant. Hence, educating them about the purpose of a wellness/recovery plan and their role in developing one is critical. *Getting in the Driver's Seat of Your Treatment: Preparing for Your Plan* was developed by Dr. Janice Tondora at the Yale Program for Recovery and Community Health to support people in preparing for and taking active roles in their service planning process. Some organizations offer orientation groups and literature that explains the service planning process. Peer staff can also review this process with the people that they are supporting.

The Wellness Recovery Action Plan®

The Wellness Recovery Action Plan® (WRAP is a process in which individuals design their own plan for sustained wellness. The WRAP, developed by Mary Ellen Copeland, is an evidence-based process that helps the person experience symptoms to identify tools and strategies for maintaining his or her own wellness, being alert to warning signs of becoming unwell, and planning a course of action to be implemented in the event of a crises. The WRAP also includes roles for supporters and healthcare providers, should the individual desire it.

WRAPs are personalized, adaptable tools that individuals can use for years to come to create meaningful, integrated lives in their communities.

Resources

WRAP

WRAP is...

DBHIDS Tools for Transformation – *Person-First Assessment and Person-Directed Planning*

Getting in the Driver's Seat of Your Treatment: Preparing your Plan (See sample recovery plan on p. 21.)

Practice 9. Provide Short- and Long-term Peer Support Services

Philadelphia's providers have worked hard to shift the service delivery model from a crisis-oriented and professionally directed model of care to one directed by the person in recovery and which focuses on his or her whole health and wellness. In the nation as a whole, however, current medical necessity requirements and other factors pressure our treatment services to remain reactive, relatively short-term interventions.

Peer staff, like all of us, must remain vigilant to the influence our crisis-oriented service culture may have on our work and take care to avoid unwittingly adopting a reactive approach to providing peer services. Should this occur, peer services might revolve primarily around meeting an individual's immediate, urgent needs, such as for housing or employment. These are important, helpful services. However, the provision of these services ought not necessarily be the end of the service relationship. It is important for the peer support staff to offer to continue to collaborate with the individual to identify additional goals, sustain contact, and support the individual with the broader goal of building a meaningful life in the community. While providing employment-related support, for instance, peer staff have opportunities to work with individuals around managing workplace stress and many of the other challenges that employment can bring. The broader goal of facilitating maximum community integration involves a longer process in which peer staff walk alongside people in their natural community contexts and assist them in growing and utilizing their personal, family, and community recovery capital to sustain their wellness over time.

Ideally, agencies intentionally ensure that the functions peer staff fulfill are distributed appropriately among people needing long- and short-term support. If the peer staff's schedule is entirely consumed with facilitating groups, conducting outreach, fulfilling paperwork requirements, and conducting telephonic support check-ins, peer staff will not have sufficient time for intensive, community-based work with individuals.

Sustained peer support relationships require different skills and strategies on the part of peer staff. One critical skill is being able to clearly set the expectations for the benefits of sustained peer support early on in the service relationship. After clearly communicating about the benefits, people are then in a position to make an informed decision about what approach fits them best at the time. Engaging people in a sustained peer support relationship usually takes several contacts, as individuals consider not only whether the service relationship is a good fit for them, but also whether it will benefit them.

The responsibility for sustaining the relationship over time belongs to the peer staff. If an individual does not see the value in sustaining the relationship, the peer staff should again demonstrate their value and seek to identify areas in which they can provide support (see Module 3 Practice 5). If an individual begins to disengage from the service relationship, the peer staff should assertively reach out to the individual rather than simply wait for that individual to reach out to them (see Module 3 Practice 17).

Practice 10. Support Multiple Pathways to Recovery

> **"Just because it doesn't work for me or I don't like it, it doesn't mean it doesn't work for somebody else. You have to be accepting of whatever pathway somebody choses."**

Peer Staff

A peer staff's lived experience with recovery and resilience can be a valuable asset when providing services, But it is also important for peers to be able to provide neutral information and support regarding the breadth of recovery pathways and experiences beyond their own.

Peer staff will likely work with individuals who have very different experiences, goals, beliefs, definitions, and chosen strategies to sustain their own recovery. An individual may be interested in medication-assisted treatment, using substances in moderation as opposed to abstaining, or joining a mutual aid group whose approach the peer support provider doesn't adhere to. Regardless of the peer staff's personal beliefs, goals, or successful strategies, peer staff need to be able to let the individual determine the direction of their own recovery and to provide relevant, practical, and desired support.

Some peer staff may have limited knowledge about pathways to recovery besides their own. Training, education, and exposure to other pathways can aid the peer staff in becoming more informed and better equipped to support others. Incorporating opportunities for peer staff to become familiar and comfortable with multiple pathways to recovery can be included in peer staff training plans (see Module 4 Practice 3). The initial interviewing and hiring process should also include an opportunity to assess whether potential peer staff are philosophically aligned with this essential practice of supporting multiple pathways to recovery (see Module 2 Practice 8).

Practice 11. Create and Offer a Menu of Options

Offering choice and fostering self-determination are key tenants of providing person-directed, recovery-oriented services. While at times peer staff may have their own ideas about the types of services that they believe would be helpful for an individual, it is important that peer staff empower and support the individual in making his or her own informed decisions regarding which services they believe would be most beneficial for them. Peer staff can foster choice and self-determination by providing an array of options. Some strategies for ensuring that services are individualized include

- providing options for where and when individual meetings with peer staff take place, and
- allowing for family, as defined by the individual, to participate in some service activities.

Creating and documenting a menu of service options provides people with a sense of the scope of supports available and affords them an opportunity to make informed choices (see sample schedule from Wedge Recovery Centers, next page). A menu of options is perhaps one of the most effective ways to promote choice and ensure that services are individualized. The sample menu below is certainly not exhaustive, but it reinforces a few principles that are consistent with a recovery orientation:

1. Managing one's illness or participating in treatment is only a small component of wellness and building a life in one's community. It takes a variety of resources, supports, and opportunities to create a healthy and meaningful life for one's self.
2. People have an opportunity to continually adjust and adapt their service plan based on their needs and preferences at the time.
3. Every contact is an opportunity to support people in expanding their vision for themselves. They may have been mandated to participate in services or come seeking supports for symptoms that have become difficult to manage. Seeing a broad array of possibilities may ignite hope and inspire people to enhance other aspects of the lives.

Wedge Recovery Centers Sample Schedule

JUNE 27, 2016
MONDAY

8AM				
	Peer-Led Socialization COMMUNITY ROOM			
9AM				
	Morning Meeting: Melanie COMMUNITY ROOM			
10AM	**Expressing Myself during Common Ground (W): Stephanny** 3RD FLOOR CLASSROOM	**Learning About Co-occurring Diagnosis (PE): Jane** GROUP ROOM 2	**Working Through Trust Issues (T): Melanie** GROUP ROOM 1	
11AM	**Morning Break**			
		Coping with Depression & Anxiety (S): Jane GROUP ROOM 1	**Expressing Self through Arts & Crafts (W)** 3RD FLOOR CLASSROOM	**Recognizing that Music Matters (P)** GROUP ROOM 4
12PM	**Lunch Support: Melanie** KITCHEN		**Daily Review: Dyshae** 3RD FLOOR CLASSROOM	
	Lunch Break			
1PM		**Afternoon Meditation (P): Peer** GROUP ROOM 1	**Book Club (S): Josh** GROUP ROOM 2	**Walking for Wellness (Community): Stephanny** MEET IN THE GREEN ROOM
2PM	**Afternoon Break**			
		Anger Management (PE): Stephanny GROUP ROOM 1	**Building Computer Skills (S): Tiffany** COMPUTER LAB	
3PM	**Peer-Led Socialization & Open Computer Lab**			

Sample Menu of Supports for Peer-Based Services

Service and Wellness Planning

- Developing a Personal Recovery Plan
- Developing a Wellness Recovery-Action Plan
- Creating an advance directive

Physical Wellness

- Connection to a primary care physician
- Accompanying to appointments
- Linking to dental care
- Linking to eye care
- Linking to support related to nutrition, fitness and wellness
- Developing an action and accountability plan related to physical health

Housing

- Exploring new housing options
- Finding emergency shelter
- Obtaining furniture and other household supplies
- Participation in supported housing

Legal Issues

- Support and advocacy with court, probation or parole officers
- Support and advocacy related to child welfare

Resource Development

- Support with obtaining clothing
- Support with obtaining food
- Support with acquiring financial resources/entitlements
- Assistance with completing forms
- Support with financial management
- Support with opening a bank account
- Support with obtaining identification

Employment

- Participation in supported employment
- Linking to other vocational services
- Developing a resume
- Practicing Interviewing
- Exploring employment options
- Linkage to consultation regarding benefits

continued

Sample Menu of Supports for Peer-Based Services, *continued*

Relationships

- Working on partnerships/family or friend relationships
- Working on expanding your network of recovery allies
- Support related to parenting
- Family participation in peer-led education and support groups

Education

- Linking to educational services
- Participation in a internship program with a community partner
- Support with applying for financial assistance

Recreation

- Assistance with developing social activities/hobbies
- Coaching regarding navigating social situations
- Rehearsing social skills
- Identification and increased engagement in new social activities in the community
- Support with identifying new meaningful roles for community participation and developing a plan for action

Spirituality

- Exploring the role of spirituality in your wellness
- Linking to faith-based services
- Identifying activities that bring meaning to your life
- Developing meditation and other stress-reducing strategies

Participation in Peer-Run Groups

- General peer support groups
- Wellness groups
- Life-skills groups
- Parenting groups
- Family Education groups

Management of Behavioral Health Conditions

- Support during transitions between levels of care
- In-person coaching sessions
- Phone-based coaching sessions
- Collaborative communication with treatment and other health providers

Source: Based on D. Loveland, D. and Boyle, M. (2005). *Manual for Recovery Coaching and Personal Recovery Plan Development*, Illinois Department of Human Services, Division of Alcoholism and Substance Abuse, 86.

Practice 12. Promote a Culture of Peer Leadership and Support

Promoting peer culture and peer leadership goes beyond hiring peer support staff to shifting the organizational culture. True peer culture is seen when the voices and experiences of people in recovery drive practice and service delivery and inform policy. A strong peer culture is present when

- people receiving services are advising on policies and procedures.
- celebrating hope and recovery is regular practice.
- people in recovery and their family members have active leadership roles in all aspects of service delivery.
- people receiving services are the authors and owners of their individualized recovery plans.
- individuals with lived experiences are hired as peer support staff and are valued team members who have active roles from initial engagement through continuing support services.

One way to promote a culture of peer leadership and support is through peer-run groups. In these groups, people in recovery come together to discuss a topic or conduct a meeting with one another. Examples of the kinds of peer-run groups that can help to promote a culture of peer support and leadership include the following:

- Peer Support Groups
- Co-Supervision Groups
- Pre-Treatment Engagement Groups
- Educational or Life Skills Groups
- Storytelling Groups

One or two peers usually facilitate these groups. Philadelphia found it beneficial to offer group facilitation skills training to people in recovery. This training included information on how to start a self-help support group and provided basic facilitation skills.

Philadelphia Guidelines for Facilitating Peer-Run Groups and Meetings

Philadelphia's Northeast Treatment Center (NET) was one of the first local programs to embark on developing not only peer leaders, but a culture of peer leadership. Among its many initiatives, NET created a Consumer Council to support individuals served and to ensure their perspectives would transform services and the nature of the service relationship. The Consumer Council is led by 14 representatives who are elected by people using NET services. Individuals who formerly used NET services may serve in a support role. The Council established formal bylaws and has several standing committees.

The Consumer Council's activities are founded on the principle of "Responsible Concern," which sets the expectation that individuals using NET services will support one another and give back to the community. Responsible Concern "cultivates the development of citizenship skills and transforms people who have wounded their communities into sources of healing for the community" (NET Consumer Council, p. 8). The Council's leadership activities, therefore, extended beyond the organization and into the community.

Among its many leadership responsibilities, the Consumer Council

- meets weekly to conduct business and plan events.
- creates and distributes a monthly newsletter.
- mobilizes individuals using NET services to engage in community volunteer activities, such as neighborhood clean-ups.
- runs a Peer Mentor program.
- manages the NET Community Recovery Center.

The peer-led Consumer Council has widespread benefits beyond improved services and outcomes. Interviews with individuals who had served on the Consumer Council showed that, among many other benefits, participation

- empowered members to take control of their treatment and recovery.
- dramatically changed the nature of NET's relationships with individual's accessing their services.
- increased a sense of community among people living with behavioral health conditions.
- promoted volunteerism.
- fostered personal growth.

Net staff also gained. Interviews with staff showed the Council instilled "a culture of hope and optimism," improved retention rates of individuals seeking services, and, among staff in particular, created "a deeper understanding of the recovery process and their role in it" (p. 12).

Source: *The Role of Clients in a Recovery-Oriented System of Addiction Treatment: The Birth and Evolution of the NET Consumer Council* by The NET Consumer Council, A. C. Evans, R. C. Lamb, & S. Mendelovich, et al., 2007.

Practice 13. Develop a Peer Advisory Council

One of the cornerstones for promoting a culture of peer leadership is the development of a Peer Advisory Council (PAC). In many of Philadelphia's PACs, organizational leaders established the overarching purpose of the PACs while council members determined the goals and activities. Many providers and peer staff worked to empower PAC members by supporting them in establishing meeting logistics and group norms and expectations and by charging them with offering recommendations to the Management Team or Executive Advisory Board regarding strategies to enhance services. In several PACs, members also serve as recovery advocates and ambassadors in their communities.

Determining PAC Membership

In Philadelphia's approach, PACs comprised individuals currently receiving services in the agency, or alumni. Ideally, agency leaders should send a formal invitation to the individual to communicate the importance of the role. In other instances, people receiving services selected their own members of the PAC.

An individual's ability to sustain their addiction recovery or effectively manage their mental health symptoms should not factor in to whether they serve on a PAC. Staff may need to be reminded that the PAC provides opportunities for leadership development, belonging, and support, and provides and avenue for people to positively impact their peers. In fact, the opportunity to be an active participant helps many people to initiate or sustain their wellness. The most important PAC membership criteria are the desire to serve and the willingness to make a commitment to active participation for a predetermined period of time.

Clarifying the Role of Staff in Relation to the PAC

Program staff play a critical role in initiating PACs and encouraging peers to participate. But when clinical or peer staff assume most of the leadership functions in a PAC, the PAC's organic growth and evolution may be hindered.

We suggest that staff refrain from becoming members, leaders, or facilitators of a PAC. In Philadelphia, staff contribute in the following ways:

- Communicating the purpose of the PAC and providing ideas about initial activities and areas of focus
- Promoting respect, safety, and confidentiality by supporting the PAC in establishing their group norms & structure
- Modeling leadership skills
- Assisting facilitators in preparing for the meeting and debriefing
- Offering to co-facilitate the first few meetings
- Supporting the process and being responsive to requests
- Creating feedback loops so that the PAC can directly sharing their ideas and concerns with senior leadership and receive follow-up

The focus and activities of every PAC will be tailored to their community and may include the following:

- Planning social activities
- Facilitating focus groups with people receiving services
- Meeting with senior leadership to offer feedback and suggestions regarding service delivery approaches
- Conducting assertive outreach and early re-engagement
- Promoting initial engagement, for example, serving as greeters in the center
- Planning recovery celebration activities
- Fundraising for social activities
- Coordinating community education and awareness raising events
- Establishing partnerships with community organizations and allies that can help to meet the needs of people receiving services

Guidelines for Establishing Group Norms for a Peer Advisory Council

Sample Invitation to Become a Member of a PAC

Practice 14. Ensure that Peer Staff Understand Their Role in Promoting Community Integration

Research and practice have demonstrated that with the right combination of housing, treatment, and other recovery and social support services, people with serious mental illnesses can live full and meaningful lives in their communities. The landmark 1999 Olmstead decision challenged the entire behavioral health community to provide community-based services that ensured that people with disabilities do not remain in isolated and segregated institutional settings. While this transformation was occurring in mental health, a similar movement was taking place within the addiction arena. For example, William White, a prominent addiction recovery advocate, historian, and researcher, maintains that addiction recovery "can be initiated in an artificial environment, but recovery stabilization and successful recovery maintenance can be achieved only in a natural community environment" (White, 2008, p. 90).

Today our challenge is moving beyond ensuring that people with behavioral health conditions receive services and live in their communities to ensuring that they are also *a part of* their communities. According to Burns-Lynch, Salzer, & Baron (2011, p. 4):

> *Simply stated, community integration is about creating opportunities for increased presence and participation in the community for individuals living with mental illnesses. It is about encouraging and supporting individual choices to actively pursue valued adult roles in life.*

Or as Salzer, Menkir, Shair, Drain, and McClain (2006) stated:

> *Community integration is the opportunity to live in the community and be valued for one's uniqueness and abilities, like everyone else. This means the opportunity to*
>
> - *work;*
> - *go to school;*
> - *be housed in the community;*
> - *have friendships with peers in recovery and individuals who have not received supports in the behavioral health system;*
> - *have meaningful social roles, such as parenting, being married or otherwise involved in intimate relationships, being a brother/sister, being a son/daughter;*
> - *engage in recreational and physical activities;*
> - *participate as a citizen, including volunteering, engaging in the political process and other aspects of civic life;*
> - *engage in spiritual and religious activities;*
> - *make choices about treatment and in all other areas of one's life to the same degree that other people can and do.*

Old views on disability were that people with physical, sensory, cognitive, or psychiatric impairments did *not* have the ability to go to work, go to school, and live in the community. The current view is that if people with impairments do not participate in their community it is not because they lack the ability to do so, but because there is a poor fit between their abilities and their environment. Peer staff create opportunities for full community integration by removing barriers and equipping people with skills, knowledge, opportunities, and supports to make new choices.

Addressing environmental barriers experienced by individuals in recovery is similar to ensuring that curb cuts, ramps, and accessible bathrooms are available for persons who utilize wheelchairs. It also includes targeting barriers that affect everyone (e.g., negative beliefs, prejudice, and discrimination) and those that affect a specific individual in a particular environment.

One of the primary functions of peer staff is to link individuals to resources and supports in the community that are pro-recovery and of value to the individual. It is helpful to remember that the word "community" here refers to both geographic community as well as communities of relevant culture, interests, and activities (i.e., LGBTQ; hip-hop; faith-based, arts, etc.). Peer staff should seek to learn and understand what community means to the individual they are serving and then collaborate around identifying relevant resources, supports and activities. While in the past, linkages to community supports may have included activities such as providing a resource list or some names and phone numbers, assertive linkages require the peer staff to be more active in the connection process.

Peer staff can facilitate community integration by

- accompanying the individual to the resource or activity.
- conducting exploratory web searches or phone calls side-by-side with the individual.
- role-playing possible scenarios the individual may experience when engaging in the resource or activity.
- providing motivational support in overcoming fears or barriers.
- supporting the individual in identifying other peers with whom to participate in community activities.
- inquiring about goals for an improved quality of life, desired social roles, and increased community participation. These can be assessed and documented in the wellness planning process.
- collaboratively identifying personal barriers to community integration and addressing obstacles that hinder individuals from being full members of their communities.
- expanding the range of opportunities for people who have mental illnesses to participate in their communities as active, equal members.
- really walking alongside people through the many of the processes of their everyday life. If their goals are related to healthier living, for instance, peer staff may help individuals develop meal plans and a grocery list that is within their budget. Peer staff may go to the grocery store with them and teach them how to read food labels. It might involve identifying online videos related to meal preparation and watching them together, or going to a local gym together to explore membership options.

"Give people the resources but don't tell people how they have to use them."

Peer Staff

The power of peer staff is that they don't tell individuals what to do or simply refer them to relevant resources. As much as possible, peer staff help people to integrate new habits and practices into their lives that will help them to sustain their wellness in their natural community settings. They do this by walking alongside them in their communities of choice and becoming involved with the activities that relate to each person's identified goals.

Resource

DBHIDS 2006, Tool for Transformation: Community Integration

Practice 15. Assertively Develop Partnerships with Other Community Organizations

In recent years, healthcare providers have become increasingly aware that nonclinical factors contribute greatly to health outcomes. Some research indicates that community and environmental factors—sometimes called the social determinants of health—have a greater impact on people's health and wellbeing than clinical services. Community and environmental factors include social support, adequate and safe housing, safe physical environments, access to transportation, nutritious food, employment, and many others. In order to address the array of environmental factors that impact wellbeing, peer staff have to strategically partner with other organizations that address these needs.

The following table suggests the kinds of collaborations that peer providers might foster in various life domains.

LIFE DOMAIN	
CIVIC PARTICIPATION	• Gather information (via a mailed or online survey, telephone interviews, etc.) from community organizations with regard to their ongoing volunteer needs, as well as provide them with a centralized resource to contact for periodic or episodic needs for volunteers. • Conduct brief presentations to help community organizations better understand how they can support individuals with behavioral healthcare conditions in becoming effective—and welcomed—volunteers in their organizations. • To make volunteering feasible for individuals receiving services, search for financial support—from the County or local foundations—to establish a fund with which to underwrite the transportation costs and other expenses involved in being an effective volunteer. • Coordinate a volunteer partner program in which people receiving services are linked with a volunteer member of the community organization in which they volunteer or wish to volunteer.
EMPLOYMENT	• Work with a speakers bureau of local employers who have had successful experiences hiring people with mental illnesses, and arrange for them to serve as spokespersons, through recognition programs and contacts with the local media, to reach out to other area employers. • Create a speakers bureau of people in recovery who have become employed and can speak to the importance of employment opportunities for their recovery. • Collaborate with potential employers and other behavioral health agencies to develop a centralized job bank. The job bank could provide a central resource for employers to post notices of available jobs to behavioral healthcare agencies, as well as serve as a mechanism for behavioral healthcare agencies to exchange information with one another on regarding job openings. • Collaborate with existing community job training, placement, and support services.

continued

LIFE DOMAIN, *continued*	
EDUCATION	• Develop a comprehensive, online listing of educational opportunities in the community, including Adult Basic Education and General Equivalency Diploma classes; business, technical and trade schools in the region; community college and four-year college programs; and graduate educational programs. • Foster partnerships with educational institutions and programs.
SOCIAL PARTICIPATION	• Survey the community to identify an array of existing social opportunities—recreational, social, hobby, athletic, etc.—and develop an informal registry for distribution to agencies and individuals. • Have peer and other agency staff conduct outreach and education to these organizations to engage them as partners in expanding opportunities for social participation for those you serve. • Identify leaders in local community organizations—e.g., in faith, service, athletic, cultural, and college settings—to work with behavioral healthcare providers in opening opportunities for broader social participation through the engagement of individuals and organizations in a common effort. • Create a mentorship program in which community members can develop one-to-one relationships and participate together in community activities in which the local volunteer and the person have a common interest.

Source: Based on Baron, R.C. (2007). *Promoting community integration for people with serious mental illnesses: A compendium of local implementation strategies*. Temple University Collaborative on Community Inclusion, Philadelphia, PA. (See link below.)

Elements of a Memorandum of Agreement

Resource

Baron, R. C. (2007), *Promoting community integration for people with serious mental illnesses: A compendium of local implementation strategies*.

Practice 16. Provide Assertive, Responsive Continuing Support

Continuing care, support, and early re-intervention have become standard practices in managing many chronic physical health conditions. For example, post-treatment monitoring and support are considered essential to helping individuals in remission from cancer sustain wellness after treatment. If there is a recurrence, post-treatment monitoring allows professionals to re-intervene early to enhance long-term health outcomes.

Similarly, addiction and mental health leaders and researchers maintain that continuing support and early re-intervention are critical components of behavioral health services and essential tools in sustaining wellness and enhancing long-term personal and family recovery. The term "continuing support" includes a broad range of services (e.g., face-to-face services, telephone support, mailed and e-mailed communications, mobilization of natural supports). Experts contend that acute models of care, which are characterized by disconnected episodes of treatment typically provided by different practitioners, are neither the most useful nor the most appropriate approach for the longer processes of recovery in serious mental health and severe substance use disorders (White, 2008; Davidson, Rowe, Tondora, O'Connell & Lawless, 2009).

Given that communities rather than treatment institutions are viewed as the ultimate context for sustained wellness, the goal of continuing support is not to extend the primary treatment episode indefinitely, but rather to help individuals and families build the resources and supports that they need in their communities to help them to manage and sustain their wellness. As a result, the emphasis is on providing support contacts within people's natural environment rather than within treatment settings. Peer support staff are ideally positioned to provide many of these continuing support services. Relationships with peer providers ensure that at least one of the most significant healing relationships will be sustained beyond treatment completion and across any future treatment episodes.

When advocating more sustained, community-based supports for people with behavioral health conditions, it is important that we do not inadvertently reinforce the myths that people with serious mental health challenges will need intensive services for the rest of their lives, or the corresponding "once a junkie, always a junkie" myth in the addiction realm (White, 2008). The reality is that people with behavioral health challenges can and do recover and achieve wellness in the context of their communities; it is important to connect each individual with an array of services and supports that will help the individual and family maintain wellness and the highest quality of life possible.

More sustained and assertive styles of monitoring and support following completion of inpatient or outpatient treatment mark a transition in thinking from aftercare (or follow-up) to continuing care.

Peer staff can provide assertive, responsive continuing support services by

- collaborating with individuals and their clinicians to begin developing continuing support plans early in the treatment process. These plans would replace discharge plans, which signal the end of the service relationship. Initiating conversations early in the treatment process allows people and their peer providers to identify potential areas of vulnerability, (e.g. few recovery allies in their circle of support), and begin to work assertively to strengthen these areas.
- creating a menu of continuing support options that incorporate multiple media options, such as face-to-face contact, telephone support, Web-based support, and mailed and emailed communications. People can choose from these options to individualize a plan that fits their life and preferences. This contrasts with more cookie-cutter plans that individuals often receive such as "go to 90 meetings in 90 days and come to our alumni group."
- utilizing new technologies such as computer and mobile applications to enhance recovery management. An example is Addiction CHESS (ACHESS) developed by NIATx (see box).
- integrating both scheduled and unscheduled contact.
- using locator forms to maintain up to date contact information and increase the likelihood of being able to sustain contact over time (link to a locator form).
- prioritizing contacts within people's natural community environments rather than within the treatment setting.
- using group-based continuing support for those in rural areas where distance and transportation challenges makes face to face contact challenging.
- training and utilizing volunteers to deliver some post-treatment support services.

> "Despite aftercare's potential for reducing relapse, our experience suggests that its implementation is not widespread. Cost, geographic distance, lack of time and peer support can reduce participation…
>
> This project is built around the premise that these barriers can be reduced with computer-based support systems providing consistent, 24 hour, in-home (or anywhere) access."
>
> The Center for Health Enhancement Systems Studies

Menu of Continuing Support Checklist

Tips for Assertive Outreach or Re-Engagement
(These tips will be beneficial for re-engaging someone who has begun to disengagement.)

Resource

Addiction CHESS (ACHESS) Video Smart Phone Tutorial

Practice 17. Intensify Support During Times of Vulnerability

Several challenges are embedded in conventional approaches to follow-up support. Traditional approaches are generally passive, generic, and static. In contrast, in recovery-oriented approaches, service providers view themselves as responsible for initiating the development of continuing support plans and maintaining contact with people rather than shifting this responsibility to the person receiving services. They also individualize the plan by increasing the duration and intensity of support based on the severity of each individual's challenges along with the depth of his or her recovery capital or assets. Finally, the plan is not a static document but it changes based on the current circumstances that people are in at any given point in time. Ideally, peer staff continually track changes in service use, housing, employment situations, relationships, and so on, and adjust the intensity of support provided based on the extent to which these changes and transitions increase vulnerability at any given points in time. For example:

- The risk of resuming substance use is greatest within 90 days after treatment, suggesting that peer staff would provide more assertive monitoring within this critical timeframe. The duration of contact (more extended years of contact) and the timing of contact (more intense during the first 90 days) seem to be more important influences on long-term recovery outcomes than the total number of such contacts or the length of each contact (White, 2008).
- Another potential point of vulnerability occurs when people transition from one level of care to another. Oftentimes, people go from highly structured environments like an impatient or residential treatment setting and then step down to a less structured environment with limited support. During transitions that involve a decrease in other services, peer staff may need to increase the intensity of support that they provide.
- When people experience significant transitions in their lives—even if these transitions are ultimately positive milestones in their recovery journey, such as getting a job, regaining custody of ones children, reuniting with loved ones—they can experience new stressors. Peer staff can assist people in navigating these new challenges without compromising their health and wellness.
- Weak linkages to continuing support also exist as people transition out of institutional settings such as prisons and psychiatric hospitals, back into their communities. These are also times when peer support services likely need to be intensified.

Practice 18. Offer Telephonic Support for Addiction Recovery

> **"We have found that peer-to-peer telephonic check-in and support has helped many members remain engaged in treatment and has encouraged a sense of accountability for both the giver and receiver of the call."**
>
> *Paula Coy, Wedge Recovery Centers*

Telephonic Recovery Support is a nonclinical approach provided by peer support staff. This innovative approach includes phone-based support to individuals seeking treatment, additional support while in treatment, as well as post-treatment follow-up and long-term recovery check-ups. Peer support staff contact individuals on a consistent, predetermined basis to offer support with recovery by sharing personal stories of hope, to assess the individual's current satisfaction with recovery and quality of life, to explore issues that may present as a current barrier to their recovery goals, and to connect them to relevant resources.

The intensity of Telephonic Recovery Support differs at various points throughout an individual's recovery journey. When someone is new to addition recovery, when they experience a setback or they are transitioning out of a treatment episode, calls should occur frequently. The frequency may be determined in collaboration with the person being served. For many people, phone-based support should not replace face-to-face contact, but rather should enhance and supplement in person support. Provide unscheduled telephone or text contacts ("I've been thinking about you today and thought I would call to say hi and see how things were going."; White & Kurtz, 2006, p. 35). All individuals should be offered telephonic support, including those who are on a waiting list, leave prior to treatment completion, or are administratively discharged (Kurtz & White, 2007).

Once a person has reached the point of stabilization or maintenance in his or her recovery journey, the calls could occur every 30 to 90 days as follow-up recovery

check-ins. Achievement of stability varies for all people. There is not an arbitrary marker for stability and maintenance. For some people, this could be a few months; for other, it could be a year or more. Regardless, Kurtz and White (2007) suggest providing telephonic support for at least five years for even the most stable of individuals, even if it is an annual recovery checkup. Research indicates that once an individuals reach five years of recovery, their chances of experiencing a set back in the recovery decreases significantly.

In order to have a successful telephonic support relationship, peer staff will need to assume responsibility for maintaining contact (responsibility of calling should not be on the individual served). Consistent with long-term peer support services, the peer support will need to fully explain the services and will need to have and maintain up-to-date phone numbers and contact info.

> "Early studies of telephone-based post-treatment monitoring and support revealed that telephone based contact was as potent in supporting continued addiction recovery as participation in traditional aftercare groups. Brief (15-minute) but sustained telephone monitoring following primary treatment has been shown to increase abstinence rates, reduce heavy drinking (by as much as 50% postpone and shorten relapse episodes, reduce emergency room visits, and reduce the need for further primary treatment."
>
> *White, 2008, pp. 111–112*

Use Telephonic Recovery Support

- with individuals on waiting lists.
- at first signs of disengagement; e.g., someone misses an appointment or group.
- at transition points; e.g., first 90 days post treatment, family tragedy, new job, moving.
- at slips.
- for engaging individuals pre-treatment.
- for continuing support or follow up.

Tips for Success

- All peer support staff who provide telephonic outreach should be trained in telephonic outreach, motivational interviewing, availability and referral to community resources, and Mental Health First Aid.
- Develop policies and procedures.
- Tape and monitor call for quality assurance purposes.

Script for Explaining Telephonic Recovery (These talking points will be helpful when offering telephonic support to folks during the initial discussions)

Telephonic Check-In Tool (These questions will be beneficial on all types of Telephonic Support Call)

Resource

Kurtz, E. & White, W. (2007), *Telephone- and Internet-Based Recovery Support Services.*

Supporting, Supervising,and Retaining Peer Staff

Why Invest in Supporting and Supervising Peer Staff?

Promising Practices:

P1. Provide Diverse Types of Supervision

P2. Provide the Right Supervisory Structure

P3. Ensure that Supervision Is Consistent, Accessible, and Helpful

P4. Ensure that Supervisors Are Skilled in Building Trust and Maintaining Boundaries

P5. Collaboratively Assess Strengths and Areas for Growth

P6. Familiarize Supervisors With Common Concerns of Peer Staff

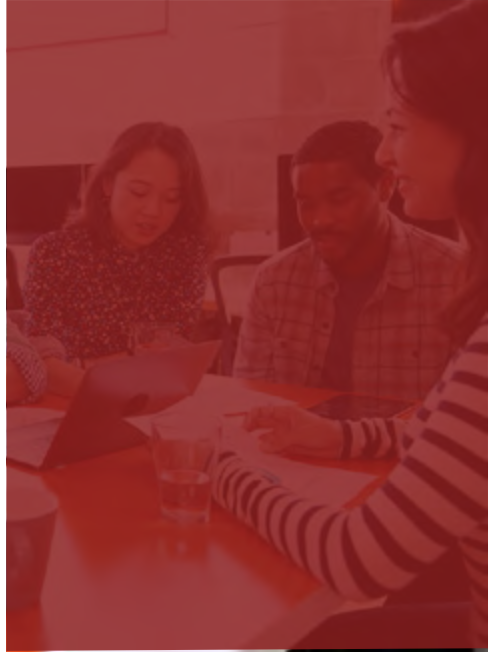
P7. Help Peer Staff Develop Time-Management and Documentation Skills

P8. Hold Peers Accountable to Recovery Values

P9. Support Continuing Education and Career Mobility

P10. Watch For and Redirect "Peer Drift"

P11. Promote Self-Care



module 4

Why Invest in Supporting and Supervising Peer Staff?

Effective supervision of peer staff can contribute to greater job satisfaction of peer workers, increase staff morale and retention, and ultimately contribute to higher quality care. Ideally, the first peer positions within your organization will be assigned to a unit or program that has strong recovery champions and a supervisor who believes in the value of peer support. It is important that peer supervisors are well versed in the nature and benefits of peer support, understand and appreciate the role of self-disclosure in the peer relationship, and are oriented toward supporting the peer staff in maximizing their contributions to the overall culture and work of the agency.

It is also important that supervisors are equipped with clear guidelines detailing expected functions for providing quality, consistent, supportive supervision. The supervisor and supervisee should have a collaborative approach to assessing job performance, strengths, growth opportunities, and training needs. The organization is responsible for establishing clear organizational guidelines and expectations related to supervision, and supervisors are responsible for communicating and implementing these guidelines. This module will provide promising practices on supervision and retention.

> **"In order to provide them with the best opportunity for success, Wedge prioritizes the supervision of peer support staff."**
>
> Jason McLaughlin,
> Chief Operating Officer,
> Wedge Recovery Centers

Peer Supervisor Skills and Capacities

- Fully understand, embrace, celebrate, and promote the unique role of peer staff and how that staff will integrate into the service team.
- Be able to support peer staff in navigating self-disclosure, boundaries, and ethical dilemmas by using the Ethical Guidelines Activity (Module 1 Practice 8).
- Promote a supportive, safe, and creative environment that involves opportunities to challenge processes, and to question and reflect.
- Collaboratively identify strengths, accomplishments, areas for growth, training needs, and professional goals, and seek out opportunities to refine skills and abilities.
- Provide constructive feedback regularly, rather than waiting for an annual review.
- Focus on developing relevant skills to meet daily demands and to prioritize the needs, satisfaction, and preferences of the people served.
- Support peer staff in developing the skills needed to understand and complete relevant documentation.
- Prioritize workplace wellness and self-care.
- Model mutual respect, consideration, and cooperation.

Source: Adapted from Tucker, S. J., Tiegreen, W., Toole, J., Banathy, J., Mulloy, D., & Swarbrick, M. (2013). *Supervisor Guide: Peer Support Whole Health and Wellness.* Decatur, GA: Georgia Mental Health Consumer Network, p. 26.

Practice 1. Provide Diverse Types of Supervision

Focus groups conducted with peer staff in Philadelphia highlighted the variability in supervision practices across agencies. Some individuals reported that they receive minimal formal supervision, making statements such as "I supervise myself the majority of the time," while others described participating in "regular weekly supervision." Inconsistency in the frequency, type, and format of supervision is not unique to peer staff. Within the behavioral health field, supervision for all staff may get overlooked in the midst of service delivery demands. To ensure that peer staff are provided with adequate and effective supervision, it may be helpful for organizations to establish clear expectations and guidelines related to supervision of peer staff and to document and provide those guidelines to all staff.

Peer staff benefit from at least three types of supervision: (1) administrative; (2) formative; and (3) supportive. Administrative supervision provides basic support related to work coordination, communication, and administration. Formative supervision helps peer staff develop knowledge and job skills related to the agency as well as to their role and profession. Supportive supervision helps peer staff to strengthen self-awareness and interpersonal skills that enable them to effectively provide services while maintaining self-care.

A DBHIDS Peer Support Focus Group was asked how often supervision occurred, and the answers varied:

"I supervise myself majority of the time."

"I ask for supervision when needed."

"We have scheduled weekly meetings, but they very seldom happen."

"Every other week supervision is scheduled."

"Once a week group meetings are held."

"Regular weekly supervision."

Supervision Framework		
Administrative	**Formative**	**Supportive**
• Orienting and placing staff • Planning, assigning, and delegating work • Monitoring, reviewing, and evaluating work • Coordinating work • Sharing information • Explaining administrative functions • Liaising with community • Assisting with time management	• Assessing strengths and growth opportunities • Identifying the knowledge and skills necessary to do the work • Providing teaching, training, and learning resources, including professional and leadership development • Using learning opportunities that arise when reviewing individuals who are receiving support • Educating other staff on the role of peer support	• Advocating • Reassuring • Encouraging • Recognizing efforts • Providing opportunities to "vent" • Giving perspective • Encouraging self-care • Creating opportunities for connecting with other peer staff

Given the three distinct types of labor outlined in the table above, it may be desirable to assign two supervisors to new peer staff so that different people can address different areas. This would allow a member of a clinical team to provide the day-to-day administrative supervision, for example, and for an experienced peer (who may work on a different team or in a different program) to provide supportive or educational supervision to the new peer staff member.

Resource

Magellan's Recovery and Resilience E-Learning Center – E-course 4: Effective Supervision of Peer Specialists

Organizational Guidelines for the Delivery of Supervision to Peer Staff

Supervision Agreement Template

Practice 2. Provide the Right Supervisory Structure

The best structure for peer support supervision will depend on organizational staffing, resources, needs, and culture. In many organizations, peer staff are supervised by a staff member who is educated in a different discipline, such as social work, psychology, nursing, or addiction counseling. Group supervision, peer supervision, and co-supervision present supplements to traditional supervisory structures involving an expert in a formal supervisory role who oversees direct reports in one-on-one meetings.

Group Supervision

Bringing peers together in a group provides an opportunity for a supervisor to efficiently disseminate information, nurture cohesiveness, and create a shared vision for the peer support services. Group supervision—as opposed to on-on-one sessions—provides opportunities for sharing experiences and knowledge, and role-playing situations and responses. The Group Supervision Tips tool provides some recommendations for conducting effective group supervision sessions.

Peer Supervision

Given that educational and supportive supervision largely serve to supply peer staff with tools specific to their roles and activities, many people maintain that only experienced peer staff can provide appropriate supervision to new peer staff. These more experienced peers may benefit from opportunities to have additional managerial training that positions them to serve in a leadership capacity with the organization.

Co-Supervision

In this model, peers meet regularly with the specific intent to collectively fulfill the supervisory role. Co-supervision is based on the idea that groups of people have more insight to offer than a single individual. No formal supervisor is present. Instead, peer staff work as a group to assume responsibility for discovering, addressing, and following up on their professional strengths and challenges in a mutually beneficial way. Among other benefits, co-supervision expands the potential for critique as well as for acquiring a broad perspective on approaches to providing peer support services.

Benefits of Co-Supervision

- Decreasing dependency on "expert" supervisors and greater interdependence between colleagues
- Increasing peer responsibility for assessing their own skills and those of their peers, and for structuring their own professional growth
- Increasing self-confidence, self-direction, and independence
- Developing consultative and supervisory skills
- Using colleagues as models and as mentors
- Building a sense of camaraderie and trust
- Creating a team characterized by mutually supportive relationships

Co-supervision may be especially useful as a supplement to regular, structured supervision, provided by a supervisor. In such cases, peers can provide one another with regular feedback, assistance, and trouble-shooting that can enhance professional development and significantly improve the quality of service provided. It is highly important to ensure that peers understand that supervisory sessions are for professional issues, not for self-care.

Co-supervision groups may vary in size. Some may have as few as two or three people. Ideally, groups should have no more than eight members participating at any given time. This provides a variety of perspectives to learn from, but the group is not then too large for everyone to benefit.

Peer support staff should play a lead role in developing a working agreement for the sessions, which may include working arrangements, ground rules, and individual responsibilities. As in other supervisory relationships, peer-to-peer supervision requires establishing trust and maintaining confidentiality.

Peers engaged in co-supervisory sessions should	
work toward…	try to avoid…
• establishing a clear working agreement for each group. • engaging with other colleagues actively, respectfully, and empathically. • communicating support and validation. • offering effective challenge, while maintaining compassion and awareness. • communicating awareness of contextual issues that affect the counseling or the co-supervision session. • understanding the unspoken process and agendas, and using that understanding to advance the task of the session. • sharing ideas, frameworks, and experiences in a way that is helpful to colleagues. • balancing the different possibilities within the time and agreed task. • being open to feedback.	• being unaware of competitiveness and telling (as opposed to suggesting or exploring) "how." • being unable or unwilling to develop and communicate empathic understanding with a colleague or with the individual being discussed in co-supervision. • failing to help a colleague explore beyond what he or she already "thinks" she knows. • establishing a hierarchical as opposed to a colleague to colleague interaction. • shying away from contention or challenge.

Group Supervision Tips

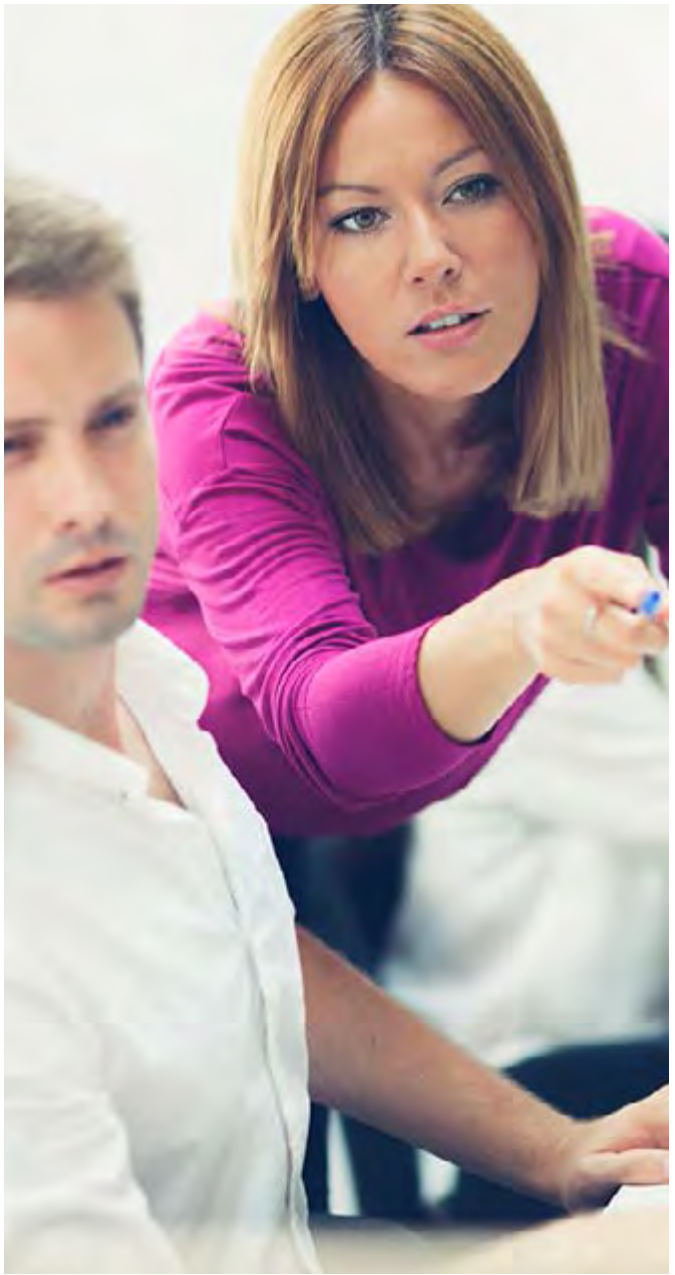
Developing a Co-Supervision Working Agreement

Tips for Giving and Receiving Reflective Feedback during Co-Supervision

Practice 3. Ensure that Supervision Is Consistent, Accessible, and Helpful

> "If I am going to continue to be a good CPS, I need training, supervision, and support."

Peer Staff



All staff benefit from consistent, accessible, and helpful supervision. Because peer support is still a relatively new service type in many organizations, structured supervision is essential. A certain degree of supervision may also be a Medicaid requirement. A study by Salzer and colleagues (2009) showed that 32 percent of peer support staff interviewed did not receive the 2-hour per week minimum supervision required by Pennsylvania's Medicaid requirements.

Elements of Effective Supervision

Consistent

Both individual and group supervision should occur on a regular and consistent basis. Staff and supervisor should have a regular time for all group and individual supervision sessions. The structure of supervisory sessions should also be predicable. Supervisory sessions should include check-ins on the progress of people being served by the peer staff as well as the peer staff's strengths and challenges around working with individuals (see Module 4 Practice 5). Supervisor and staff should follow an agenda or set format for every supervision session. Supervisors should track next steps for each of the people receiving services that they discuss. Supervisors and the peer staff member should also collaboratively document next steps and priorities that emerge related to the staff member's professional development and training needs. This will ensure that supervisors can follow-up appropriately and provide a consistent supervision experience.

Some supervisors have an open-door policy, enabling staff to drop in at any time to discuss work-related issues. An open-door policy is ideal when supervising people who provide direct service. However, an open-door impromptu session should never replace regularly scheduled supervision sessions. In the behavioral health field, too many supervisory sessions occur solely in the open-door/drop-in structure. As a practice, this type of supervision is not beneficial to the staff, persons they serve, or the team. An open-door policy should supplement the consistent supervision approach. Many staff appreciate a blend of an open-door policy as well as structured and consistent supervision.

According to Tucker and colleagues (2013, p. 27) individual supervision meetings should focus on the following:

- **Performance.** How are things going? What is going well? Are the demands of the job manageable? Concerns, time management, documentation, consultation regarding specific situations or individuals receiving services.
- **Education and Growth.** Skill development; identifying and sharing of agency and community resources; review progress toward professional goals and training needs.
- **Relationships with Co-workers.** What is going well? Where are some struggles? What strategies will move the situation forward?
- **Management Issues.** Unit and organizational policies and procedures that impede progress toward transformation or act as barriers to service delivery.
- **Personal Wellness.** Any challenges getting in the way of performing duties or factors that can improve performance and wellness on the job.

Accessible

As peer staff go about their work, they inevitably encounter situations in which they are supporting people in crises. It is crucial that peer supervisors are accessible and available to assist peer support staff in these situations. Assistance could be offered in person, over the phone, via email, or through other communication pathways. The key is to be responsive, to return phone calls and respond to emails in a timely manner.

Helpful

When staff need to obtain billable hours and support people in the community, their time is extremely valuable. Supervisors should strive to ensure that supervision sessions are always relevant and helpful, and should check-in with staff to explore the extent to which the sessions are meeting their needs and how they might be enhanced.

Shadowing

Shadowing is an effective approach for supervising and training peer support staff. Shadowing consists of observing leadership styles, relationship-building skills, problem solving skills, and general behaviors during normal interactions and activities. There are two approaches to peer staff shadowing. In one approach, a supervisor or leader shadows peer support staff in the field to observe his or her performance, interactions, and

> **"Shadowing an existing worker for a minimum period of time is very valuable."**
>
> *Paul Sachs, Executive Director, NHS Philadelphia and Tess Zakrzwski, Program Director, Germantown Recovery Community*

relationships with the individuals they serve. While shadowing peer staff, supervisors assess how effectively the person delivers peer support services.

In the second approach, the peer staff shadows an administrator, supervisor, or other peer support person during daily activities. It is especially beneficial for peer support staff to shadow leadership in management meetings, group facilitation activities, community partnership meetings, and so on. Providing staff with opportunities to shadow leadership affords staff a unique understanding into organization culture, decision making, and diplomacy. Such opportunities also allow peer support staff to observe individual leadership styles and management skills and obtain a greater understanding of the context within which they do their work.

When peer support staff experience difficulties with activities or functions, they may benefit from opportunities to shadow more experienced peer staff. For instance, experienced peer support staff in your organization may be excellent at initial engagement and building rapport. Peer support staff who are newer to the organization may not be as comfortable with the initial step, may not know what to say when they first meet someone, may not know how much of their personal story should they divulge upfront, and so on. The supervisor could arrange for new peer support staff to shadow more experienced peer staff person during an initial meeting, greeting people when they walk in the door, or during a visit to a community organization to do outreach or community education.

Debriefing the shadowing experience is essential for continued growth and development. When a supervisor is shadowing peer support staff, the supervisor should share and discuss the Shadowing Tool for Supervisors with the peer support person before and after the shadowing experience. An ideal approach would be to ask peer support staff to assess themselves using the same tool, and then meet to discuss the experience, using the tool as a guide.

"I did not know when or how to not step on toes when trying to save the world, and simple things like copying my supervisors on emails goes along way. I could have used a mentor or someone to explain this to me and show me the ropes."

Peer Staff

Mentoring

Pairing new peer staff with a peer staff mentor can smooth the new hire's transition into the workplace. The peer mentor can help educate new peer staff about agency culture and practice and hasten the rate at which a new hire becomes fully productive. When feasible, having the peer support mentor and new peer support staff share a workload can allow for more opportunities for hands-on learning and support. Consider the following when matching mentors to new staff.

The peer mentor has time and capacity to adequately support new peer staff. It may be necessary to relieve peer mentors of some tasks or allow for schedule accommodations as they take on this added responsibility.

The peer mentor is comfortable and competent in their role, possesses a clear understanding of the job, and can articulate the peer staff role. The peer mentor should be well acclimated to the role prior to being asked to orient new staff.

The peer mentor is able to model desired work performance. It can be helpful to check in with the peer mentor about the specific guidance they will be providing around concrete items such as documentation processes, when to seek out support around ethics and boundaries dilemmas, and use of workspace and resources.

The peer mentor is able to model a positive attitude and desired agency culture. The peer mentor should exemplify a positive attitude and would not be likely to transmit negative opinions or experiences.

The peer mentor has a clear understanding of the expectations and opportunities for growth in their role as mentor. The supervisor should acknowledge the leadership development opportunities inherent in the peer mentor role. Supervisors should also be clear about areas they want the peer mentor to cover with new staff (see checklist).

The peer mentor and new staff are compatible. Based on available knowledge, match peer mentors with compatible new peer staff.

Resource

D. Loveland and Boyle, M. (2005). *Manual for Recovery Coaching and Personal Recovery Plan Development*, Illinois Department of Human Services, Division of Alcoholism and Substance Abuse.

Peer Mentor Checklist Facilitator's Guide

Peer Mentor Checklist

Individuals Served Progress Review Tool

Shadowing Tool Facilitator's Guide

Shadowing Tool

Supervision Session Documentation Template

Practice 4. Ensure that Supervisors Are Skilled in Building Trust and Maintaining Boundaries

Effective supervisors recognize that each individual they supervise will bring prior experiences, beliefs, ideas, and associations around supervision to the supervisory relationship. Supervisors bring their own past experiences, beliefs, and assumptions into the supervisory relationship, as well. It is therefore important to begin the supervisory relationship by sharing these experiences, expectations, hopes, and fears to build trust and pave the way for a shared understanding of what the current supervisory relationship will look like. A supervisor's willingness to be open, appropriately transparent, and attentive to the peer staff's ideas, concerns, and needs will help shape the trajectory of the supervisory relationship. Particularly in the early stages, and certainly throughout the relationship, a supervisor's verbal and nonverbal responses should demonstrate care, respect, and appreciation for what the peer staff is sharing or experiencing. It is important that both supervisor and supervisee view the supervisory relationship as a safe space for the supervisee to receive support, perform honest introspection, candidly share difficulties, and expose vulnerabilities. To that end, an important task of the supervisor is to intentionally foster trust.

Some peer staff will enter into the supervisory relationship with little to no prior experience with formal supervision. Others may have had formal supervision but will be new to the framework that will guide the supervisory relationship. It is therefore important for peer staff to receive the knowledge and tools that will prepare them to use supervision effectively. Such training should define the supervisor's role, introduce and clarify the framework for the supervisory relationship, describe the benefits of supervision, and allow peer staff to conduct self-introspection around attitudes, ideas, and beliefs about supervision. This orientation should also introduce tools for peer staff to use when preparing for supervision, such as an agenda or preferred format for discussing the needs and strategies used to support the people they are working with. One practice that can assist with this is collaboratively

completing a Supervisor Agreement at the initiation of the supervisory relationship and sharing the organization's guidelines and expectations related to supervision.

It is important for the supervisor and supervisee to distinguish between supportive supervision and treatment. Because supportive supervision involves addressing workplace tensions and at times involves asking staff to reflect, supervisors can find themselves bordering on the role of psychotherapist, recovery support service provider, or sponsor. Whereas the goal of supervision is always to assist staff in improving their ability to meet the needs of the people they support, the goals of counseling are often to support personal growth, improve insight and self-understanding, or to facilitate behavior changes. The difference between supportive supervision and treatment may be a gray area at times. Particular attention to maintaining the distinction ought to be paid when the peer staff has transitioned within an agency from the role of service recipient or volunteer to peer staff. The supervisory relationship should not slip into functions that mirror sponsorship or therapy. Redefining relationships and boundaries should be an intentional effort guided by the supervisor and may require occasional revisiting early on in the peer staff's employment. It may require supervisors to utilize supervision themselves as specific instances arise.

Gail Dixon (2004) maintains that the boundary between therapy and supervision is determined by how the supervisee's personal issues and concerns affect their work. When personal issues emerge in the context of supervision, the supervisor should consider the following critical question: Does this impact the delivery of services and supports to the people being served? If personal issues impede the person's job performance, supervisors may make the person aware of the presence and impact of these issues. If the person is not already engaged in his or her own psychotherapy or counseling outside of the job, the supervisor may even recommend the person do so in order to improve their job performance. In such cases, supervisors may recommend that staff make use of an Employee Assistance Program or seek their own care as covered through their health insurance. Under no circumstances, though, does it become the supervisor's job to provide the psychotherapy, counseling, or recovery support services.



Practice 5. Collaboratively Assess Strengths and Areas for Growth

Taking time at the beginning of the supervisory relationship to collaboratively identify peer staff strengths and opportunities for growth will lay the groundwork for future areas of focus. It is helpful for supervisors to coach peer staff through the process of conducting their own self-assessment. Individuals who are new to providing peer support services may not have enough experience to spontaneously identify their strengths and challenges that are relevant to their new role. As a result, some may find it helpful to review a list of potential areas of strength and opportunities for growth as a starting place for the conversation.

Creating a safe space for peer staff to explore and share vulnerabilities without fear of being judged or penalized is a critical step in creating a supportive supervisory relationship. At times it may be helpful for supervisors to share some of their prior or current growth opportunities as a way of normalizing the fact that professional development is a continuous process. If individuals struggle to identify their strengths, supervisors can offer some of their observations about what is going well.

Exploring evolving strengths and opportunities for growth should be part of ongoing supervision sessions. It is especially important to provide constructive feedback regarding areas for improvement prior to formal performance evaluations so that staff have the opportunity to learn and implement new approaches. These supervision strategies are applicable to all staff and are not unique to supervising peer staff.

- Interim House Inc. Staff Feedback Form
- Aspects of Diversity Self-Assessment Facilitator's Guide
- Aspects of Diversity Self-Assessment Form
- New Employee Self-Assessment Facilitator's Guide
- New Employee Self-Assessment Tool
- Supervisor's New Employee Orientation Checklist

Practice 6. Familiarize Supervisors With Common Concerns of Peer Staff

Based on the experience of peer staff members in Philadelphia and around the nation, we have a better understanding of the concerns and challenges that commonly arise as peer staff become integrated into treatment settings. To avoid being caught off guard, familiarize peer supervisors with the following common concerns:

- Peers feel isolated and experience difficulty integrating into the service team.
- Clinical staff distrust or feel threatened by peers.
- Peers drift toward professionalization or performing traditional service roles.
- Peers lack career advancement opportunities.
- The roles of volunteers and paid peer providers are not clearly differentiated.
- Not all staff support multiple pathways to recovery and well-being.
- Roles are unclear to clinical staff, peer staff, or both.
- Training is inadequate and does not address key issues.
- Peers experience time-management challenges.

As important as it is to be aware of these common concerns, it is just as critical that supervisors seek to proactively prevent them from defining the experience of peer staff in your organization. Concerns that are present but unaddressed have the potential to unravel even the most well-intended peer support services and create a toxic residue that can influence future efforts.

Supervisors are often in an ideal position to facilitate meaningful conversations between clinical and peer staff that can help to identify and address or prevent these issues from taking root in the organizational culture. These conversations can normalize experiences, promote transparent conversations, and provide opportunities for many staff to be a part of shaping new organizational norms. During staff meetings for instance, peer supervisors might raise a few of these concerns and frame them as concerns that are common to treatment organizations during the initial years of integrating peer support services. Supervisors could then pose the following kinds of questions:

- Is this concern important to us?
- How might we prevent this concern from defining our experience?
- What would we need to do differently?
- What might we need to do more or less of?
- What additional supports or opportunities might we need?
- Is there anything specific that the leadership team can do to ensure that we address or prevent the concerns we've discussed today?

Peer staff may often be the first to raise concerns about long-standing organizational practices that may impede rather than promote recovery. Peer staff in Philadelphia reported that, during such times, it was not helpful or productive for supervisors to view their concerns as personal issues or the result of hypersensitivity. Instead, it is helpful for supervisors to remember that the introduction of peer staff often represents

a culture change for the organization. With that change, familiar practices and policies will need to be re-examined and in many cases re-aligned. When peer staff raise such concerns, supervisors may try the following:

1. Seek to understand the concern. Speak to more than one peer staff member, if possible, and also to individuals served, if appropriate.
2. Explore the concern in the context of recovery-oriented values and guiding principles. Does the current state conflict with any of the principles that guide the delivery of recovery-oriented services?
3. Provide support to the peer staff by validating the concern and ensuring that he or she does not feel isolated.
4. Brainstorm desired solutions and alternatives that might be more recovery-oriented.
5. Advocate organizational change:
   - Create an opportunity for the peer staff member to share his or her concerns directly with the executive sponsor.
   - Present the identified solutions to begin the dialogue about concrete changes.
   - If needed, provide examples from similar organizations or from the literature to support your recommendations.
6. Broaden the dialogue beyond supervisors, peer staff, and executive sponsors to include other organizational staff. This step is critical to promote sustainable culture changes in the organization.
7. Ensure that the peer staff who raised the concern is not "scapegoated." This can easily happen, as it is often easier for stakeholders to believe that the issue is a personal problem rather than an organizational challenge.

Agency Assessment of Common Peer Staff Concerns Facilitator's Guide

Agency Assessment of Common Peer Staff Concerns Scale

Practice 7. Help Peer Staff Develop Time-Management and Documentation Skills

Time Management

In one survey of peer support staff, nearly one in four respondents described experiencing "stressful work environments that include untenable work productivity standards" and "excessive paperwork" (Ahmed et al., 2015). In addition to ensuring that workloads are reasonable for peer staff, training and support around time management can help peer staff combat stress and potential burnout. Providing time-management tools and incorporating these tools into supervision sessions can be very helpful. It is important to work with peer staff around their preferences, strengths, and skills when selecting specific time-management strategies and tools. Some peer staff may find electronic time tracking devices on their computer or smartphone helpful. Others may prefer a hard copy of a time tracker.

Paying attention to messaging related to time management can minimize the likelihood that staff will feel that they are being micromanaged or that they are not viewed as capable of managing their own time.

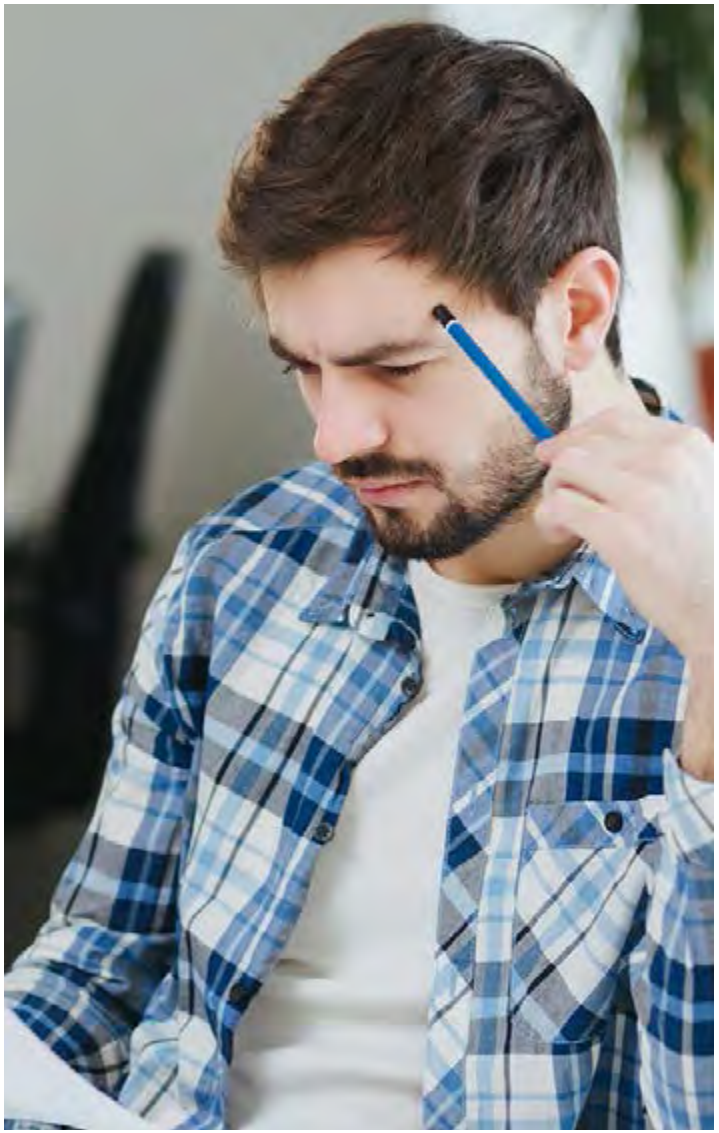
Paperwork

> **"There is a lack of time to do paperwork; this leads to time management and burnout challenges."**
>
> *Peer Staff*

One of the biggest concerns expressed by peer staff is the burden of paperwork and documentation. Peer staff frequently disclose that they spend more time completing paperwork

than they do actually helping people. It is essential that supervisors regularly monitor the proportion of time peer staff spend on administrative tasks such as documentation versus time they spend on providing direct services. If the time allocation appears to be out of balance, supervisors should work directly with staff to identify and address the contributing factors. For example, is the peer staff provider unsure about how to complete the required documentation? Are they providing services to too many people? Does the agency collect the same information on multiple forms? Are peer staff required to provide an unnecessary amount of detail that is more consistent with a clinical note? It is also critical for the supervisor to help peer staff understand how the documentation will be used, and why it is important. Ensure that peer staff understand that documentation is more than an administrative burden. Instead it charts each person's recovery journey and can provide an opportunity to reflect back on successes, accomplishments, and lessons learned. Documentation also provides a mechanism to help staff ensure that the focus of their contact with people is consistently linked to their stated recovery goals.

Ideally, the conversation regarding documentation began during the interview process and peer staff are prepared to perform this essential function of their role. Periodic quality assurance reviews of charts and documentation help ensure that paperwork is completed on time and efficiently, and confirms there is not duplication or unrequired documentation. Coaches may need some administrative tips and time-management suggestions on how to best complete the paperwork while meeting the needs of the people they are serving. For some peer staff, this may be the first time that they were required to complete a significant amount of documentation, and it can feel overwhelming.



Supervisor Tips for Documentation

Documentation Self-Assessment Tool Facilitator's Guide

Documentation Self-Assessment Tool

Practice 8. Hold Peers Accountable to Recovery Values

Peer staff, like all staff, should offer services that are grounded in a recovery-oriented approach. Supervisors should not assume that someone with lived experience in recovery will automatically understand and endorse recovery-oriented approaches. Peer staff may have received behavioral health services in conventional service settings and may have internalized many of the beliefs and approaches to service delivery that they experienced. As examples, peer staff may need additional coaching around the following issues to ensure that their approaches are recovery-oriented.

Embracing multiple pathways to recovery. Peer support providers may promote what worked for them and become frustrated when people do not choose the same path that they pursued, such as going to treatment, incorporating a faith-based support system, engaging in 12-step fellowships, creating a Wellness Recovery Action Plan, and so on.

Practicing assertive outreach and continued re-engagement. Some peer staff have internalized the conventional belief that the people they serve have to be motivated enough to truly benefit from services. In the mental health arena, they may have heard that providers should not be working harder for the person than the person is prepared to work for themselves. In the substance use disorder arena, they may have heard that people have to hit bottom before they are truly motivated enough to make changes in their lives. These kinds of messages hinder the work of recovery coaches. Addiction recovery coaches, for example, may be working with someone who has had multiple relapses or slips. Rather than continuing to meet with the person at the point of their need, they may disengage from the person and communicate to their supervisor that the person is being manipulative, not following through with their commitments, and not ready to receive support. These kinds of messages and actions are not consistent with a recovery orientation, which instead recognizes that motivation is an outcome of the service relationship, rather than a prerequisite for the service relationship (White, 2008). When others reduce support, peer staff are typically the ones who should be increasing their support.

Supporting people in determining their own recovery goals. Peer staff may have had experiences where their personal goals had to be reviewed and approved by clinical staff before they could pursue them. They may have been told for instance, that they were not ready to work, to live independently, or to manage their own money. If they experienced a hierarchical, provider-driven service relationship for years, they may unconsciously assume that it is now their role to provide that same kind of direction, advice, and monitoring for others. Supervisors need to clearly understand the nature and purpose of person-driven services, along with other recovery-oriented values, and ensure that the service approach of their peer staff is consistent.

Providing community-based services. Peers may need to be encouraged to help people to build their natural support system in their community, rather than primarily providing services within the agency.

Practice 9. Support Continuing Education and Career Mobility

> **"We've found that training, continued staff development and encouragement to pursue additional formal education are extremely helpful in promoting retention."**
>
> Laura Boston-Jones,
> North Philadelphia Health System

Career mobility is just as important for peer staff as it is for nonpeer staff, but this is an area that historically has not been given adequate consideration. In fact, several Philadelphia-based agencies reported that their peer staff lasted only about five years before "burning out," when in fact, many peer staff who had served for multiple years reported that they were seeking promotions and new challenges. Peer staff positions should not be dead-end positions, and peers should no more be expected to work in a position with no advancement opportunities than their nonpeer colleagues.

Some state certification boards offer career pathways for individuals who enter the behavioral health field in a peer support role. The Pennsylvania Certification Board, for example, created a career ladder that details the path a person can take from Certified Recovery Specialist to a Certified Alcohol and Drug Counselor. It can be helpful to investigate whether your state's credentialing bodies offer career mobility pathways and options for peer support staff to continue their education.

At the same time, we should be careful not to assume that individuals in peer support roles automatically aspire to take on clinical roles. The two functions are different. It is helpful if organizations develop a nonclinical career path for peer providers. Some organizations provide initial opportunities for people in recovery to serve as volunteer peer mentors, then as paid peer support staff, then as supervisors of peer staff, and then to expand their role beyond working primarily with individuals to engaging in promoting more community and cross-system partnerships.

Many peer staff find that the depth and breadth of their one- to two-week training does not fully prepare them for the complexities that they later find themselves navigating, both in terms of work environments and professional roles. To maximize the impact of peer staff, it is critical to ensure an intentional approach to continued staff development through ongoing training that is specific to their role as peers. The content for continued education will be influenced by the areas that they find most challenging. Peer staff in Philadelphia commonly requested more support in the following areas:

- Understanding and effectively navigating community resources
- Conflict resolution
- Ethics and boundaries
- Fulfilling documentation requirements
- Group facilitation
- Motivational interviewing
- Self-care
- Story telling
- Team building
- Time management
- Trauma-informed care
- Using technology

In addition to formal training opportunities, peer staff can benefit from participating in cross-provider networking opportunities.

> **"If possible, peer networks should be established where peers from different agencies can come together to support each other."**
>
> Laura Boston-Jones,
> North Philadelphia Health System

While also receiving emotional support from peers who are conducting the same or similar work, peer staff participation in cross-provider networking opportunities can provide access to resources, strategies, tools, lessons learned, and new ideas to be brought back to the agency. Although time constraints and work responsibilities may make it challenging for peer staff to participate, the longstanding benefits for the staff, those they serve, and the agency at-large make this cross-agency networking a worthwhile priority.

Loveland and Boyle (2005) suggest that supervisors work collaboratively with peer support staff to synthesize information from assessments, shadowing experiences, and supervision sessions to generate individualized training plans. Training plans are focused learning opportunities on a particular topic or skill area that peer staff needs to acquire. They are written contracts that describe the specific skill to be acquired, what information was used to initiate the plan, how the skill will be acquired, what materials or trainings are needed, a deadline for reviewing the training plan, and one or more measurable objectives indicating that the skill has been acquired.

Resource

Pennsylvania Certification Board Career Ladder

Practice 10. Watch For and Redirect "Peer Drift"

Much of the power of peer support services lies in the ability of peer staff to use their lived experience to connect with their peers, to inspire hope, and to support people in building their ideal life despite any limitations imposed by their conditions. At times, however, as a result of being embedded in a clinical culture, peer staff can inadvertently become over-professionalized and begin to function as junior clinicians or case managers. This is often referred to as "peer drift" and it can make peers less relatable to the individuals that they desire to support. Peer drift also occurs when the expectations for the role or job performance of peer staff begins to more closely resemble that of clinical staff.

Supervisors can inadvertently encourage peer drift by applying the same policies regarding scheduling, self-disclosure, and boundaries that they have for clinical and other staff to peer staff without deliberately thinking through how these policies may impact the effectiveness of peers. As an example, in many treatment settings, service delivery is site based. People come to the agency to receive services. Clinicians have a very structured weekly schedule for one-to-one, family, and group sessions. To maximize their effectiveness in supporting people with building a meaningful life in their community, peer staff need to spend a significant amount of time working alongside people in their natural community contexts; they also need significant flexibility within their schedules so that they can be available to assist people with unanticipated needs.

It is the supervisor's role to identify and address existing policy and procedural tensions that may hinder the work of peer staff.

Practice 11. Promote Self-Care

Helping professions in general, and behavioral health professions in particular, have high levels of staff burnout and turnover. Self-care should be routinely encouraged for all staff. Given that many peer support staff are new to the role, and that this is also a new role for many organizations, it is imperative that supervisors encourage peer staff to focus on self-care and wellness. Many of the peer support staff interviewed in Philadelphia's focus groups disclosed that they felt overextended, overwhelmed with paperwork, and frustrated when people they were serving did not stay connected. Some peer support staff also reported neglecting their own wellness routines in order to focus on work. Offering peer staff regular opportunities to come together to discuss workplace wellness and self-care strategies can be a helpful mechanism for added support and team building.

The following could be helpful to supervisors and peer support staff in assessing and maintaining their own self-care and wellness:

- **Recovery Wellness Cafés.** These events were started during the initial stages of Philadelphia's recovery transformation process. They are peer run and provide opportunities for peer staff from different organizations to connect, learn from, and support one another.
- **Self-Care Assessment.** This is a helpful tool for recognizing personal strengths in self-care and areas for improvement, as well as for establishing specific strategies toward enhancing personal self-care.
- **Compassion Fatigue Assessment.** This tool is helpful in recognizing compassion fatigue and for establishing goals for enhancing personal strategies to address and prevent compassion fatigue.
- **Workplace Wellness Recovery Action Plan.** Some peer staff find it helpful to write an employment Wellness Recovery Action Plan (WRAP) to facilitate wellness in the workplace and address burnout.

Many programs and supervisees new to peer support ask what to do if a peer staff member experiences a lapse in abstinence or experiences a challenging time with their symptoms of mental illness. It is important for supervisors to recognize that penalizing peer staff for exhibiting symptoms of the condition that qualified them for the role of peer provider would be out of alignment with recovery values and principles. A lapse or recurrence of symptoms can be viewed in the same light as other chronic medical conditions such as cancer, diabetes, or high blood pressure, and a punitive approach

should be absent in the response to a lapse or a recurrence of symptoms just as it would be with any of these other chronic health conditions.

In the supportive supervision model, the supervisor in many ways serves as a coach. Supervision during and following a lapse or challenging time should be focused on working with the individual to determine their readiness to perform the essential functions of their role and providing them with the needed supports and resources to be successful. These situations illuminate the critical value of having a clear, specific job description. It will be much easier for the supervisor and peer staff to work together to accurately assess whether or not they are ready and equipped to perform their role, if the skills, characteristics, and tasks are concretely outlined in the job description.

It is also important for supervisors to avoid slipping into position of primary support, counselor, sponsor, or recovery support service provider at this time and to instead direct the person to utilize their personal treatment, wellness plan, and recovery support team. Tucker and colleagues (2013) note that it is important for supervisors to avoid addressing personal issues in a supervision setting. Because many supervisors have provided counseling services, and many peer support staff have received counseling services, it is important to maintain boundaries and role clarity. A supervisor providing clinical support would create stressful and unacceptable role confusion. If a supervisor believes a staff person may be experiencing behavioral health related challenges that are impacting work performance, Tucker and colleagues suggest referring the staff member to the Employee Assistance Program or an outside service.

Continuing to foster a safe, supportive, empowering, and encouraging supervisory relationship will be of great importance during this time. It is possible that internalized stigma and shame, along with fear of discrimination, will be present for the peer staff; the supervisor's ability to demonstrate understanding and support will be powerful in enhancing the supervisory relationship.

Supervisors should treat the discussion of peer staff's recovery status with other supervisees and agency staff in the same manner as they would any other health condition. The supervisor should not discuss details surrounding a peer staff's recovery status with others outside of those who need to be aware of it, (e.g., Human Resources department, senior supervisors). Reminding peer staff that self-disclosure is a tool utilized to instill hope can help them identify when, how, and why they would disclose their lapse or recurrence of symptoms to persons they serve.

Resource

DBHIDS Employment Wellness Recovery Action Plan presentation

- **Recovery Wellness Cafés Facilitator's Guide**
  - **Recovery Wellness Cafés**
- **Self-Care Assessment**
- **Professional Quality of Life Scale** (Compassion Satisfaction and Fatigue)
- **Professional Quality of Life Scoring**

City of Philadelphia
DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH
and INTELLECTUAL disABILITY SERVICES

tools

Module 1 Tools

Module 3 Tools

Module 2 Tools

Module 4 Tools

Module 1 Tools

Practice 1. Communicate Senior Leadership's Commitment to a Recovery-Oriented Service Philosophy

- Peer Staff Integration Leadership Commitment Checklist

Practice 2. Solicit the Perspectives of People in Recovery, Family Members, and Staff Early in Your Process

- Focus Groups and Listening Sessions Facilitator's Guide
- Sample Questions about Integrating Peer Support

Practice 4. Conduct an Agency Walk-Through

- NIATx Walk-Through Activity Facilitator's Guide
- Observation Guide for Role Players

Practice 5. Examine the Extent to Which Agency Language Is Recovery Oriented

- Language Evaluation Activity Facilitator's Guide
- Language Evaluation Worksheet for Role Players

Practice 6. Anticipate, Address, and Reframe the Concerns of Existing Staff

- Myth or Fact Activity Facilitator's Guide
- Myth or Fact Worksheet
- Myth or Fact Answer Sheet
- Deep Dive: What's the Difference between AA Sponsors and Peer Support Staff?

Practice 7. Conduct an Agency Self-Assessment

- Diversity and Inclusivity Organizational Assessment Tool
- Environmental Wellness Tool
- Recovery Self-Assessment Facilitator's Guide
  - RSA Checklist
  - RSA Checklist Planning Companion
  - RSA Sample Goals
  - RSA Discussion Guide
  - RSA Action Plan for Change
  - RSA Activity Debriefing

Practice 8. Examine and Create Shared Expectations Related to Boundaries and Ethics

- Ethical Guidelines Activity Facilitator's Guide
- Ethical Guidelines Activity
- Four Dilemmas
- Recovery Coaching Intimacy Continuum
- Ethics Activity Debriefing

Practice 10. Clarify Expectations and Roles of New Peer Staff

- Assessing Role Clarity and Readiness

Peer Staff Integration Leadership Commitment Checklist

To assess the status of your organizational leaders' commitment to integration, each person on the Change Management Team should complete the checklist. Use the results to guide discussion about next steps and to set priorities.

Please mark your response to the following statements	AGREE	DISAGREE	UNSURE
Our team displays a commitment to integrating peer staff in our organization.			
Our team has shown me compelling evidence as to why we need to integrate peer staff in our workplace.			
Our team has taken the time to create a sense of urgency regarding the integration of peer staff into our organization.			
Our team truly believes there is a need to complement previously established practices with regard to peer staff integration.			
There is a sense that our team understands the long-term effects that integrating peer staff will have on our workplace.			
Our team has committed resources for successfully integrating peer staff.			
Our team rewards people for their commitment to integrating peer staff.			
Our team has established systems and procedures to measure the progress of integrating peer staff.			
Our team's process for integrating peer staff is communicated frequently.			
Activities that are inconsistent with our team's commitment to successful integration of peer staff have been clearly explained.			
Our team doesn't just talk about the vision for successfully integrating peer staff, but leads by example.			
Our team gives clear (not mixed) signals regarding peer staff integration in our organization.			

Adapted with permission from *The Heart of Change Field Guide: Tools and Tactics for Leading Change in Your Organization* by D. S. Cohen, 2005, Boston, MA: Harvard Business Review Press.

Focus Groups and Listening Sessions Facilitator's Guide

PURPOSE

To solicit stakeholder perspectives and make plans to address concerns

MATERIALS

Prepared list of questions to guide discussion (sample provided)

TIME

1–2 hours

COSTS

Light refreshments before the focus group (optional); facilitator fees and note taker fees, if any; staff time and any individual stipend or incentives for participating

DIRECTIONS

Each group should have no more than 15 participants, as more participants make it difficult to ensure everyone has an opportunity to contribute.

The facilitator will welcome the group and ask a series of open-ended questions. An assistant facilitator or other attentive person should take notes. People want to know what will be done with the information they offer. So early on, facilitators should clearly articulate how the information gathered from the groups will be used. Let participants know that their insights will be used to enhance and refine services.

SAMPLE INTRODUCTION

"Good morning, and welcome. Thanks for taking the time to join our discussion today. My name is _____, and I will serve as the facilitator for today's group discussion. Assisting me is _____, who will be writing down your ideas and recommendations. The purpose of today's discussion is to hear your ideas and recommendations about improving services at [Organization]. We are in the early stages of making some exciting changes at our agency. One of the changes is integrating people with lived experience in mental health or addiction recovery into our staff to provide a variety of non-clinical supports to the people we serve. We want to ensure that any changes we make are grounded in the desires and needs of the people we serve. We also know that our staff has extremely valuable perspectives based on their many years of providing services. Our hope is to bring all of our perspectives and experiences together to improve the quality and effectiveness of our services. There are no right or wrong answers to the questions I am about to ask. We expect that you will have differing points of view. Please share your point of view even if it differs from what others have said. If you want to follow up on something that someone has said, if you want to agree, disagree, or give an example, feel free to do that. I am here to ask questions, listen, and make sure everyone has a chance to share. We're interested in hearing from each of you. So if you're talking a lot, I may ask you to give others a chance. And if you aren't saying much, I may call on you. We just want to make sure we hear from all of you. We will be taking notes to help us remember what is said, but we won't write down your name. Let's begin with each of you telling us your name and how long you have been associated with [Organization]."

Sample Questions About Integrating Peer Support

SAMPLE QUESTIONS FOR STAFF

- What excites you about bringing peer support services into the organization?
- What concerns you about bringing peer support into the organization?
- How do you believe your job will be different when peer support staff join the team?
- In what ways could peer staff interfere with or disrupt clinical services?
- In what ways could peer staff enhance clinical services?
- What would you recommend to leadership to ensure that our efforts are successful?
- Based on your experiences, are there other ways that we could improve the quality of our services?

SAMPLE QUESTIONS FOR PEOPLE IN RECOVERY, FAMILY, AND ALLIES

- What does recovery mean to you?
- What helped you in your (or your family's/household's) recovery journey?
- What was not as helpful in your (or your family's/household's) recovery journey?
- Are there particular kinds of services or help that you are not receiving that you think could be helpful in your recovery journey?
- As an organization, we are planning to include peer support services. These are services provided by people who have lived experience with a mental health or substance use condition. They will provide emotional support, help connect people to community resources, assist people in identifying and working toward their personal goals to improve their health and quality of life, and may lead support groups and help with wellness planning. Our peer staff will assist people with anything that is nonclinical but that impacts their health and wellness. This includes being a resource for finding employment and safe housing. What are your thoughts about these services?
- If you are currently receiving treatment services, or have received services in the past, what would you have changed about your experience?
- What are your hopes for the future?

PURPOSE

To gain a sense of how your organization and services are experienced by person seeking services

MATERIALS

Notebook or other way for role players to record all their thoughts and feelings about this process

TIME

Varies

COSTS

None

DIRECTIONS

Plan the Walk-through

Ask someone on your Change Management Team to play the role of "individual seeking services" and another person to play the role of "family member" or "ally." We recommend that role players include someone familiar with the process under review, such as someone receiving services, as well as someone who is not involved with that particular function on a daily basis. Role players should be detail oriented and committed to making the most of this exercise. To ensure that their experiences will be as realistic and informative as possible, ask them to present themselves as dealing with a behavioral health disorder that they are familiar with and that the staff they encounter are familiar with.

Let the staff know in advance that you will be doing the walk-through exercise. Ask them to treat the role players as they would anyone else. However, role players may also ask questions of staff about aspects of their jobs.

continued

DIRECTIONS, CONTINUED

Conduct the Walk-through

The role players will attempt to access services just as a typical individual seeking services and family member or ally would. The walk-through may begin with a person's or family member's first contact with your agency: a call for information about services.

Role players should try putting themselves in the shoes of an individual seeking services or family member. They should observe their surroundings and consider what someone in their position might be thinking or feeling at any given moment. Role players should record their observations and feelings in a notebook. See the Observation Guide for Role Players.

At each step, role players may ask the staff to tell them what changes (other than hiring new staff) would improve the experience for the individual, family member, ally, or staff. The role players should jot down the staff person's ideas and feelings as well as their own.

Study the Results

Make a list of the areas that need improvement along with suggested changes. Include the perspectives of the role players and staff.

As a team, discuss what went well with the walk-through, what didn't go well or was confusing, and what should be done differently the next time.

Act on the Results

After completing their walk-throughs, agency teams in Philadelphia debriefed by considering the following questions:

- Did you discover anything of concern that you hadn't noticed before? Were there any surprises?
- Are there observations or lessons learned that may be applicable to other parts of the agency?
- What are some aspects of the agency that you can improve with little effort?
- What are some immediate next steps?
- What are some more substantial or long-term challenges?

OUTPUTS

- Notes from walk-through
- List of practices that seem to work well from walk-through
- List of practices that do not work well or need to be changed

FIRST CONTACT

- When you called the agency, did you get a busy signal, voice mail, an automated greeting, or a live person?
- Did the agency offer you an appointment on your first call?
- How many days would a typical person have to wait for the next available assessment appointment?
- Would a typical person have to miss work to make the appointment?
- Would a typical person have difficulty reaching the site?
- Is transportation available?

ASSESSMENT

On the day of the appointment, arrive at the clinic or office with this question in mind: What would it be like if you had never been to the site before? Complete the entire intake process. Fill out all required forms. If the person seeking services is required to undress, you should undress.

Continue to note your impressions as someone new to behavioral health treatment:

- Does the family member or ally typically accompany the individual through the entire intake process?
- How long does a typical person spend in the waiting room?
- Is a urine test required?
- What did you feel during the assessment process?
- Which staff participated in the process?
- What kinds of questions were asked, and what impact did those questions have on you?
- How many days would a typical person have to wait until the next available first treatment appointment? Ask staff: What percent of individuals don't show for their treatment appointment?

Language Evaluation Activity Facilitator's Guide

PURPOSE

To ensure the formal and informal language used throughout the organization is respectful and accurate and promotes recovery

MATERIALS

Language Evaluation Worksheet, as well as forms, signage, and other communications under review

TIME

Varies; can be an ongoing activity

COSTS

None

DIRECTIONS

The Change Management Team will appoint a work group to assess the organization's language; be sure to include your organization's communications professionals and people in recovery.

Use the Language Evaluation Worksheet to make a list of spoken and written terms used in the organization that refer to people in recovery and the services available to them. Note who uses the terms and the circumstances in which the terms are used.

Your discussion group may want to give thought to the following questions:

- Is the term "person-first"?
- Is the term nonjudgmental?
- Does the term convey positive regard for the people to whom it is applied?
- Is the term accurate and clear?
- How would someone not in our field react to hearing or reading the term?
- Is there a better term?
- What would individuals receiving services say if they knew particular terms were used to describe them?

If new terms are preferred, educate staff about why that is the case. Disseminate information about language change in staff meetings and through other internal communications, such as all-staff emails. Remake printed materials to reflect changes at the earliest feasible time.

Tips

1. Organizations may find it helpful to assess language in a systematic way, starting with public-facing materials and working toward internal materials.
2. When a decision is made to replace a term, keep a list of the preferred terms in an organizational style guide. Ensure communications staff and consultants use the style guide.
3. Review and update the style guide annually.

Language Evaluation Worksheet for Role Players

DATE OF REVIEW: _____

Term or Phrase	Who Uses It and Where?	Does the Term Reflect Recovery-Oriented Values?	Is There a Better Phrase or Term?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Myth or Fact Activity Facilitator's Guide

PURPOSE

To prepare for the integration of peer staff by addressing and reframing common misperceptions and stigmas

MATERIALS

Myth or Fact Activity Sheet for each participant

TIME

1–2 hours

COSTS

Reproducing Activity Sheet; facilitator fees, if any

INTRODUCTION

Use the language in the toolkit to explain to your leadership team and staff the importance of conducting an initial self-assessment. Explain that you are going to begin an agency assessment by doing some self-reflection exercises to help all of you identify some core beliefs that may impact the people that you serve.

DIRECTIONS

Provide each participant with the Myth or Fact Activity Sheet and allow them 5–10 minutes to read and answer. Then read each statement one at a time and allow the group to discuss their responses. Referencing the answer key, then provide a response.

WRAP UP

At the end of the exercise allow time for discussion. Staff should explore what has influenced their attitudes and beliefs. Then consider the basis for these perceptions or beliefs. For example, are these beliefs based on empirical data (i.e., research)? Are these perceptions based on the staff's experiences of providing services? Were these beliefs perhaps handed down by previous generations of practitioners? Do these beliefs apply to all people with behavioral health conditions, including the staff's own loved ones, or do they apply only to those served in publicly funded agencies and programs? How willing are the staff to reconsider the accuracy of their perceptions and beliefs?

Tip

This activity promotes greater insight and increases staff's capacity to work effectively across cultures. In order to maximize its impact, careful consideration should be given to selecting the right facilitator, framing the discussion, and creating a safe environment for open discussion.

Myth or Fact Worksheet

Can you tell the difference between a behavioral health disorder myth and fact?

Please check **Myth** or **Fact** for each statement.

1. Many people with mental illnesses are fragile and may not be able to handle the stress of the job. ☐ **Myth** ☐ **Fact**

2. Many people with substance use disorders relapse; therefore, they are more likely to take time off, be a no-show, and be less reliable. ☐ **Myth** ☐ **Fact**

3. Peer staff may not have as much work experience as other staff and may not be able to handle the administrative demands of the job. ☐ **Myth** ☐ **Fact**

4. Peer staff are less likely to say the wrong things to clients. ☐ **Myth** ☐ **Fact**

5. The addition of peer staff may make my job more complicated. ☐ **Myth** ☐ **Fact**

6. Peer staff will take some of our jobs away. ☐ **Myth** ☐ **Fact**

7. Peer staff should report when they are on medication and when they stop taking their meds. ☐ **Myth** ☐ **Fact**

8. Peer staff are just as accountable as clinical staff. ☐ **Myth** ☐ **Fact**

9. Peer staff and AA sponsors have different roles. ☐ **Myth** ☐ **Fact**

10. Peer staff need to be in long-term recovery before they can be effective in a peer support or leadership role. ☐ **Myth** ☐ **Fact**

11. Individuals with mental illness are more likely than the general population to engage in violent acts, so we need to be particularly careful when selecting peer staff. ☐ **Myth** ☐ **Fact**

12. People with a serious mental illness such as schizophrenia are not likely to recover. ☐ **Myth** ☐ **Fact**

Myth or Fact Answer Sheet

Can you tell the difference between a behavioral health disorder myth and fact?

1. Many people with mental illnesses are fragile and may not be able to handle the stress of the job. **Myth**

   Jobs in behavioral health are stressful for everyone, and peer staff are no different. Self-care is therefore an important practice for all behavioral health staff, not just for peer staff. It is true, however, that peer staff are asked to take on the additional burden of disclosing some of their most personal experiences and to use these experiences to help others pursue recovery. Recovery is hard, taxing, and ongoing work. Far from being fragile, people who have gained mastery over their own behavioral health conditions could instead be viewed as demonstrating considerable persistence and resilience.

2. Many people with substance use disorders relapse; therefore, they are more likely to take time off, be a no-show, and be less reliable. **Myth**

   All employees, including peer staff, may need time off because of illness. And staff who have not disclosed a behavioral health disorder may nevertheless take time off because of it. The same expectations for sick time and accommodations for illness should be applied to all employees, including peer staff. Regarding the belief that high-stress occupations may precipitate relapse, research has consistently shown that people are less likely to relapse when working than when they are experiencing prolonged involuntary unemployment.

3. Peer staff may not have as much work experience as other staff and may not be able to handle the administrative demands of the job. **Myth**

   Although some people join the peer workforce with limited work experience or educational attainment, peer staff can learn how to manage administrative details of their jobs, and others may manage effectively with supports. The individual staff member, in collaboration with human resources personnel, can design accommodations for cognitive impairment, limited literacy, or other issue. Any staff person assuming a new role and level of responsibility may benefit from additional support for a period of time to ensure that they are confident in fulfilling the requirements of their position.

4. Peer staff are less likely to say the wrong things to clients. **Fact**

   Trained and supervised peer staff may be less likely than other staff to say the wrong things. In fact, by virtue of their own life experiences as service recipients, peer staff may be more attentive to protecting people's privacy and to not using offensive or insensitive language when talking to their peers.

5. The addition of peer staff may make my job more complicated. **Myth**

   Peer support provides an important and useful complement to existing behavioral health services and supports. Peer staff can be especially effective in encouraging people to seek care and acting as a bridge between service users and other staff. Peer staff have been found to lessen the load carried by other practitioners, enriching clients' lives while allowing other staff to concentrate on their respective areas of expertise.

continued

Myth or Fact Answer Sheet
continued

Can you tell the difference between a behavioral health disorder myth and fact?

6. Peer staff will take some of our jobs away. **Myth**

   There has long been an unmet need for qualified staff for behavioral health positions, and this trend is likely to continue. Regardless, peer support complements, rather than replaces, clinical and rehabilitative services and has been seen to enhance, rather than diminish, the work of other behavioral health providers. In states where labor unions play a prominent role in care delivery, concerns about job security have been addressed, in part, by including new peer positions under the scope of an appropriate union.

7. Peer staff should report when they are on medication and when they stop taking their meds. **Myth**

   All employees, including peer staff, may take medication for a variety of illnesses. Some staff who do not identify as peer staff may take medication for behavioral health conditions. Employers do not ask nonpeer employees for a list of diagnoses and medications. The same HR and supervision expectations should be applied to all employees, including peer staff.

8. Peer staff are just as accountable as clinical staff. **Fact**

   Peer staff, like all other employees, are expected to conform to policies and regulations regarding confidentiality and Health Insurance Portability and Accountability Act laws. Training and supervision support compliance with policies and laws, and peer staff are just as responsible as any other staff for protecting personal information.

9. Peer staff and AA sponsors have different roles. **Fact**

   AA Sponsors and peer support staff differ in many significant ways. Look at a summary of these differences.

10. Peer staff need to be in long-term recovery before they can be effective in a peer support or leadership role. **Controversial**

    There is no magic number that indicates when someone is able to provide peer support services. Individuals define recovery initiation differently, and every individual has a unique recovery experience. Identifying a moment of stability and readiness to provide peer supports is arbitrary, at best. More important than knowing the length of time in recovery is assessing the applicant's ability to provide high-quality peer support services. The assessment should include a thoughtful analysis of the whole person, including their skills, personal attributes, understanding of recovery-oriented approaches, prior work experience, problem solving abilities, and other defined qualities. It is not the hiring committee's role to assess the person's health status or employment readiness but rather to determine how well the person would perform the specific job functions.

continued

Can you tell the difference between a behavioral health disorder myth and fact?

For some people, however, concerns arise regarding how many goals must be achieved before a person is considered "recovered." Similarly, how much life success is considered "normal" (Ralph & Corrigan, 2005)? Many individuals with lived experience in mental health recovery find the definition of recovery as outcome to be insufficient. As an alternative, many people view recovery as a process. From this vantage point, people are in recovery when they are concerned about their psychological well-being, when they are trying to manage their symptoms, and when they are engaged in the process of pursuing their life goals. The process approach to recovery shifts the attention from measuring whether change has occurred or an end state has been achieved and instead focuses on psychological well-being, personal fulfillment, and hope regarding the future (Ralph & Corrigan, 2005). Particularly for many people with mental health conditions, recovery is not considered an event that has a start date.

The process perspective contrasts with the more outcome based viewpoint of many people in addiction recovery who mark their time in recovery based on the date that they last used alcohol or other drugs. Some addiction recovery advocates propose establishing a certain length of time in recovery as a prerequisite for assuming a peer staff role (White, 2008). We remind organizational leaders that it is not clear that the length of time one is in recovery is directly associated with one's ability to succeed in a peer support role; hence, we do not recommend a hiring criterion based on length of time in recovery. This issue will be discussed more fully in module 2.

11. Individuals with mental illness are more likely than the general population to engage in violent acts, so we need to be particularly careful when selecting peer staff. **Myth**

    The vast majority of people with mental health problems are no more likely to be violent than anyone else. In fact, people with severe mental illnesses are more likely than the general population to be victims of violent crime. You probably know someone with a mental illness and don't even realize it because many people with mental illness are highly active and productive members of our communities.

12. People with a serious mental illness such as schizophrenia are not likely to recover. **Myth**

    Studies show that people with serious mental illness can and do get better. Some people who meet diagnostic criteria for a serious mental illness overcome their disabilities and accomplish their life goals without any formal treatment. Others benefit from treatment, services, and community support to reduce symptoms and improve their quality of life (Ralph & Corrigan, 2005). For everyone with a serious mental health condition, recovery means that their illness need not define their lives. They can pursue life goals that are important to them and experience a sense of purpose, satisfaction, contribution, and community belonging. Peer support staff who are in recovery from a serious mental illness demonstrate that recovery is possible.

Deep Dive: What's the Difference between AA Sponsors and Peer Support Staff?

According to William White, sponsors and peer support staff have different roles.

SPONSORS

- serve as representatives of a voluntary, financially self-supported recovery mutual aid society.
- develop a sponsor–sponsee relationship in relative isolation from professional helpers.
- provide support within a particular recovery program.
- are limited to serving those who have "a desire to stop drinking" and who have sought help within a local recovery support program.
- focus on the use of Twelve Step Tools (personal story sharing, meetings, step work, literature, sober social activities).

PEERS

- work as representatives of a formal service organization bound by accreditation, licensing, and funding guidelines that shape accountabilities within the peer staff or recovery coach role that are not present in the sponsor–sponsee relationship.
- provide services within the context of a multidisciplinary service team and a formal treatment plan or recovery plan.
- provide recovery support across multiple religious, spiritual, and secular frameworks of recovery. Peers emphasize a philosophy of choice that recognizes the legitimacy of multiple pathways to long-term recovery.
- serve those who may not yet have a desire to stop drinking and those who are seeking recovery but are opposed to participation in a particular recovery program.
- work within a formal service continuum and are specifically trained to access a broader range of recovery-supportive services, including education, employment, health care, housing, day care, transportation, counseling for co-occurring problems, and more.

Charities Review Council

DIVERSITY AND INCLUSIVITY ORGANIZATIONAL ASSESSMENT TOOL

The nonprofit sector plays a unique and critical role in our society, addressing the needs of a broad cross-section of people and places. Because of this, it is increasingly important that nonprofits seek to be inclusive and embrace diversity in all its forms to be responsive to the changing demographics of the larger society. By striving to be diverse and inclusive, a nonprofit strengthens its ability to achieve its mission by bringing together individuals with varied experiences, perspectives, and skills.

To assist in assessing how a nonprofit is progressing in its journey toward diversity and inclusivity, the following tool is meant to facilitate a greater understanding of where an organization currently stands and spark conversations toward meaningful action steps.

This self-assessment tool is designed to be a starting point and organizations are encouraged to add or change items as makes sense. By using this tool, it is hoped that the nonprofit will gain greater insight around three key questions:

- Who is the community we serve?
- How do we as an organization reflect the community we serve?
- What are some action steps we can take to reduce any barriers to broader diversity and inclusivity?

Please note that actions taken by an employer to increase diversity and inclusivity may present legal compliance challenges and should therefore only be undertaken after seeking expert advice.

Suggested Instructions

The use of this assessment tool is not mandatory. There is no one way to use this tool. However, it tends to work best if one person acts as the lead in facilitating conversations within your nonprofit to complete the assessment. Often nonprofits will have the assessment process be part of a board committee's work and the lead person works closely with this group.

Although each question is structured to have a yes or no answer, the questions are meant to be a conversation starter more than anything. For this reason, there is an accompanying column for explanations to give more detail. Information dealing with protected classes (race, ethnicity, religion, etc.) should be maintained anonymous and confidential. It must be kept apart from employment records. Please consult your legal counsel if you have any questions regarding this.

When the assessment is complete, it is recommended that the full board of directors review it. This may be something you will want to share with staff, volunteers or other stakeholders as well, however, great care should be given to preventing sensitive information regarding individuals from being shared. Please do not return the assessment to the Council.

eliminating racism empowering women ywca

continued

Diversity and Inclusivity Organizational Assessment Tool *continued*

KEY STEPS FOR INCREASING ORGANIZATIONAL DIVERSITY

Assessment of Diversity and Inclusivity	Yes/No/ Unsure	Explanation
Has your organization defined diversity? Diversity encompasses a number of characteristics that will differ from organization to organization, for example, age, immigrant status, dis/ability status.		
Is your organization active in serving and building relationships in diverse communities (as defined by your organization and as it relates to your mission)?		
Has your organization agreed to and examined your reasons for seeking diversity? (Why, how it relates to mission, barriers, etc.)		
Has your organization had in-depth conversations about what you know and what you do not know as relates to this topic?		
Has your organization developed a statement of purpose? (Begin with a firm commitment to diversity that is written, visible, and an expectation of all board and staff members.)		
Are your organization's staff, board, and volunteer trainings aligned with your goals around diversity?		
Has your organization identified and addressed systematic barriers that preclude people from being fully engaged in the diversity and inclusivity effort?		
Has your organization gone through diversity training?		
To the extent permissible under the law, does your organization reflect its commitment to diversity in its recruitment, retention, mentoring and leadership development practices?		
Is diversity a core value that is structurally integrated throughout your organization? (Diversity council, affinity groups, marketing materials, policies, etc.)		
To the extent permissible under the law, do your employee evaluations reflect accountability to your diversity standards?		
Does your organization have allies/mentors or another structure in place for members to help navigate, answer questions, stand up when something inappropriate/discriminatory is said, etc.?		

continued

KEY STEPS FOR INCREASING ORGANIZATIONAL DIVERSITY, CONTINUED

The three things this organization is doing well in terms of creating and sustaining a diverse, inclusive environment are:

1.

2.

3.

The top three priorities for increasing this organizations commitment to diversity are:

1.

2.

3.

This organization will create a timeline for taking action on these priorities by: (date) _____

Signed:

_____

Executive Director (date)

_____

President of the Board (date)

How does your organization feel to the people you serve? Does it feel safe, welcoming, open, inviting?

The physical space of your facility not only affects the health and well-being of those served, it also affects the stress and fatigue of staff members.

Three dimensions of the healthcare environment affect health and well-being (Dijkstra et al., 2008):

- Architectural features (e.g., spatial layout, room size, windows)
- Ambient features (e.g., lighting, odors, sound/noise)
- Interior design features (e.g., color, artwork, plants, furniture, signage, and wayfinding)

How healing is your environment? Circle the environmental descriptors that best describe your facility:

adequate size/inadequate size
appealing/unappealing
attractive/unattractive
bright colors/muted colors
cheerful/gloomy
clean/dirty
colorful/drab
comfortable/uncomfortable
complex/simple
convenient/inconvenient
diffuse lighting/direct lighting
drafty/stuffy
efficient/inefficient
empty/full
free space/restricted space
fresh odor/stale odor
functional/nonfunctional
good acoustics/poor acoustics
good colors/bad colors
good lighting/poor lighting
good lines/bad lines
good temperature/bad temperature
good ventilation/poor ventilation
huge/tiny
inviting/repelling
light/dark
neat/messy
new/old
orderly/chaotic
pleasant/unpleasant
pleasant odor/unpleasant odor
quiet/noisy
roomy/cramped
soft lighting/harsh lighting
sparkling/dingy
tidy/untidy
uncluttered/cluttered
uncrowded/crowded
well-balanced/poorly balanced
well kept/rundown
well organized/poorly organized

(Kasmar, 1970)

continued

ENVIRONMENTAL FACTORS OF HEALTHCARE SETTINGS AFFECTING HEALTH AND BEHAVIOR OUTCOMES

Environmental Factor	Health/Behavior Outcome
Visual/auditory privacy (curtains v. walls, multi-bed v. single bed rooms, stimulus shelter)	Disclosure, stress
Noise/sound (paging system, alarms, staff voices, telephones, acoustic conditions, multi-bed v. single bed rooms)	Stress, sleep disturbance, cardiovascular function
Spatial orientation (wayfinding/signage, administrative information such as maps and verbal directions)	Stress
Lighting (natural and artificial)	Depression, length of stay, pain
Nature exposure (view of nature through a window, plants, water features, gardens, photos/videos of natural scenes)	Stress, anxiety, fear, anger, attention, cardiovascular function, pain, sense of control
Seating arrangements (chairs arranged in a grid v. radially, or both)	Socially supportive interaction

Dijkstra et al., 2006; Ulrich et al., 2004

GROUP EXERCISES

1. Describe or draw a picture of the layout of your program space.
2. In what ways does the space promote inclusion? Exclusion? Healing/recovery? Does this space allow you to do all the things you need? If not, can you reorganize the space?
3. What types of space do you need to fulfill your purpose? What do you currently have and not have?
4. What are some possible strategies to change the space you have or gain access to the space you need?

Source: Adapted from SAMHSA's *Consumer-Operated Services Evidence-Based Practices Kit,* 2011.

After completing the Environmental Awareness Tool, consider the following questions:

- What items in the tool presented new ideas to members of your team about the physical condition or presentation of your facility?
- What items in the tool represent strengths for your facilities?
- Where could you improve most dramatically? What would it take to do that?
- Which items has your team identified as priorities?
- What did the team identify as first steps?

INTRODUCTION

Explain that you are going to begin the organizational self-assessment by doing some self-reflection exercises to help identify some new strategies that may positively impact the people you serve.

PURPOSE

To prepare for the integration of peer support by discussing and identifying simple strategies that can easily be implemented

MATERIALS

Recovery Self-Assessment Checklist, Planning Companion, Sample Goals, Action Plan, and Activity Debriefing

TIME

1–2 hours

DIRECTIONS

Provide each participant with the Recovery Self-Assessment Checklist. Allow everyone 10–15 minutes to read and answer the questions. Distributing the Discussion Guide and allow participants 5–10 minutes to review the information. Allow the group time to discuss each question (10–15 minutes). After the group discussion, provide individuals with the Action Plan. Allow the group 15–25 minutes to discuss their responses. Staff should then complete the Action Plan for Change. All participants should identify two or three simple strategies that they commit to implementing in the near future. Allow 15–25 minutes for the Action Planning Document.

WRAP UP

At the end of the exercise allow additional time for discussion. Staff should discuss what small changes they identified and what immediate steps they will take.

Please indicate the current presence or absence of the following recovery activities, values, and practices at your organization.	Currently a well-developed practice	Practice needs to be strengthened	Not applicable
Factor 1. Life Goals			
Staff members actively assist people with the development of life goals that go beyond symptom management and stabilization.			
Staff routinely encourage individuals in the pursuit of educational and/or employment goals.			
Our staff focus on their main role of assisting each person with fulfilling their individually defined goals and aspirations.			
Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.			
Procedures are in place to facilitate referrals to other programs and services if the agency cannot meet a person's needs.			
Staff play a primary role in helping people become involved in activities not related to recovery.			
Staff use a language of recovery (i.e., hope, high expectations, respect) in everyday conversations.			
Agency staff believe that people can recover and make their own treatment and life choices.			
The achievement of goals by consumers and staff is formally acknowledged and celebrated by the agency.			
Staff and clients are encouraged to take risks and try new things.			
Staff are knowledgeable about special interest groups and activities in the community.			

continued

Recovery Self-Assessment Checklist
continued

Please indicate the current presence or absence of the following recovery activities, values, and practices at your organization.	Currently a well-developed practice	Practice needs to be strengthened	Not applicable
Factor 2. Involvement			
People in recovery work alongside agency staff on the development and provision of new programs and services.			
People in recovery are regular members of agency advisory boards and management meetings.			
People in recovery are involved with facilitating staff trainings and education programs at this agency.			
This agency provides structured educational activities to the community about mental illness and substance use disorders.			
People in recovery are routinely involved in the evaluation of the center's programs, services, and service providers.			
Agency staff actively help people become involved with activities that give back to their communities (i.e., volunteering, community services, neighborhood watch/cleanup).			
This center provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery.			
The development of a person's leisure interests and hobbies is a primary focus of our services.			

continued

Recovery Self-Assessment Checklist
continued

Please indicate the current presence or absence of the following recovery activities, values, and practices at your organization.	Currently a well-developed practice	Practice needs to be strengthened	Not applicable
Factor 3. Diversity of Options			
This center actively attempts to link people with others in recovery who can serve as role models or mentors.			
Criteria for exiting or completing services at our agency are clearly defined and discussed with individuals upon entry to the program.			
People are given the opportunity to discuss their sexual health and spiritual needs and interests.			
This agency provides a variety of treatment options (i.e., individual, group, peer support, holistic healing, alternative treatments, medical) from which people in recovery may choose.			
Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.			
At this center, individuals who are doing well get as much attention as those who are having difficulties.			
Factor 4. Choice			
People in recovery have access to all their treatment records.			
Our staff do not use threats, bribes, or other forms of coercion to influence a person's behavior or choices.			
Staff at this agency listen to and follow the choices and preferences of individuals seeking services.			
People in recovery can choose and change, if desired, the therapist, psychiatrist, or other service provider with whom they work.			
Progress made toward goals as defined in collaboration with the individual is monitored on a regular basis.			
Most services are provided in a person's natural environment (i.e., community, workplace).			

continued

Recovery Self-Assessment Checklist
continued

Please indicate the current presence or absence of the following recovery activities, values, and practices at your organization.	Currently a well-developed practice	Practice needs to be strengthened	Not applicable
Factor 5. Individually Tailored Services			
Our center offers specific services and programs for individuals with different cultures, life experiences, interests, and needs.			
All staff at this agency regularly attend trainings on cultural competency.			
Helping people build connections with their family and transitioning to a community setting is one of the primary activities in which staff at this agency are involved.			
Our center provides education to community employers about employing people with mental illness and/or addictions.			
Every effort is made to involve significant others (spouses, friends, family members), community services (i.e., the local community mental health center) and other natural supports (i.e., clergy, neighbors, landlords) in the planning of a person's services and transition to the community, if so desired.			

Adapted from "From Rhetoric to Routine: Assessing Perceptions of Recovery-Oriented Practices in a State Mental Health and Addiction System" by M. O'Connell, J. Tondora, G. Croog, A. Evans, & L. Davidson, 2005, *Psychiatric Rehabilitation Journal*, *28*(4), 378–386.

FACTOR 1: LIFE GOALS

Staff members begin to function as recovery guides, developing a multidisciplinary recovery plan in collaboration with the client, which focuses on the client's career and life goals, while also helping clients learn to live with their disabilities.

FACTOR 2: INVOLVEMENT

"Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners" (Tondora & Davidson, 2006, p. 59). The agency is aware of the need for peer input to help clients and staff members understand fully the possibility of recovery. Peers are involved with planning, implementing, and evaluating new and existing programs. Staff members value and actively support client involvement in hobbies and social and community activities, both formal and informal. The agency is involved as a leader in the community, educating and collaborating with other service groups to fight stigma, network with new partners, and increase the general public's awareness of recovery.

FACTOR 3: DIVERSITY OF OPTIONS

Related to individualized recovery planning is the ability of the agency to provide a range of services. At the agency level, "a wide range of interventions and contributors to the planning and care process are recognized and respected and sought out to support each person's recovery journey" (Tondora & Davidson, 2006, p. 62). "The agency actively attempts to link people in recovery with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs [Factor 3.1]." Finally, "recovery plans consider not only how the individual can access and receive needed supports from the behavioral health care system and the community, but how the individual can, in turn, give back to others" (Tondora & Davidson, 2006, p. 63).

FACTOR 4: CHOICE

With the understanding that the civil right of self-determination is valid for all clients unless and until a court rules otherwise, recovery planning is based on the needs, desires, goals, and decisions of the client. Clients have a right to access their treatment records, change providers, and make decisions that are considered risky by the staff members. Clients are treated with respect and "[i]nterventions are aimed at assisting people in gaining autonomy, power, and connections with others" (Tondora & Davidson, 2006, p. 15).

FACTOR 5: INDIVIDUALLY TAILORED SERVICES

In the collaborative process of recovery planning, existing connections are supported, new relationships are encouraged, and staff members understand and exemplify diverse cultures, lifestyles, and possibilities for the client. Community inclusion is a highly valued recovery goal, and, in fact, a human right. "Individuals are not required to attain, or maintain, clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment" (Tondora & Davidson, 2006, p. 60).

Source: The RSA Planning Companion was developed by the University of Texas Center for Social Work Research based on the RSA and the *Practice Guidelines for Recovery-Oriented Care for Mental Health and Substance Use Conditions* developed by the Yale Program for Recovery and Community Health for the Connecticut Department of Mental Health and Addiction Services (2008).

RSA Sample Goals

In the table below, we share examples of best practices in each of the five factor areas. If you would like to improve your agency's practice in this area, please consider the examples provided and imagine how this would look in your organization, or how it could be created by your change team.

Life Goals	Involvement	Diversity of Options	Choice	Individually Tailored Services
Staff actively assist people in recovery with the development of career and life goals that go beyond symptom management and stabilization.	Peers comprise a significant proportion of representatives to an agency's BOD, advisory board, or other steering committees and work groups.	Within the planning process, a diverse, flexible range of options must be available so that people can access and choose those supports that will best assist them in their recovery.	Policies are established and maintained that allow people in recovery maximum opportunity for choice and control in their own care.	Providers are trained in the recovery guide model of care, whereby interventions and strategies are offered as tools that the person can use in his or her own recovery.
Peers provide support through sharing their story of recovery, and they model attainment of non-illness-related goals.	Peers are routinely invited to share their stories with current service recipients and/or to provide training to staff.	The agency actively attempts to link people in recovery with others in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs.	There is a systematic request for consumer input regarding the programs, policies, and quality of care offered by the agency. A peer should have responsibility, whenever possible, for collecting input from clients.	Through peer recovery support, the agency provides hope for a better future, models an increased and valued role for peers, and demonstrates an understanding of the client's powerful role in his or her recovery planning.
Staff believe in recovery, and they focus care on promoting recovery rather than preventing relapse.	Assertive efforts are made to recruit peers for a variety of staff positions for which they are qualified.	Individuals are not required to attain or maintain clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment.	Progress made towards goals of the recovery plan is monitored on a regular basis.	Community inclusion is valued as a commonly identified and desired outcome. Opportunities for employment, education, recreation, social and civic involvement, and religious participation are regularly identified and compiled in asset maps, capacity inventories, and community guides.
All staff use recovery-oriented language in everyday conversations.	Each person served is provided an initial orientation to agency practices.	Goals and objectives of the recovery plan are not defined by staff but are defined by the client with a focus on building recovery capital and pursuing a life in the community.	Clients have access to all their treatment records.	The agency offers specific services and programs for persons with different cultures, life experiences, interests, and needs.

continued

RSA Sample Goals *continued*

Life Goals	Involvement	Diversity of Options	Choice	Individually Tailored Services
Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests	Policies are established and maintained to allow people in recovery maximum opportunity for choice and control in their own care.	Practitioners are willing to offer practical assistance in the community contexts in which their clients live, work, learn, and play.	Practitioners are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship. Practitioners encourage individuals to write their own crisis and contingency plans.	Performance and outcome indicators for the agency and its staff reflect a continuous process involving expectations for successful client outcomes in a broad range of life domains.
Asset maps and capacity inventories are created collaboratively by actively involved community stakeholders and agency staff members.	Self-disclosure by employed persons in recovery is respected as a personal decision and is not prohibited by agency policy or practice.	Staff address needs of clients as they work to find a place in the community, such as by providing evening and weekend services.	The individual has the ability to select or change his or her service providers within relevant guidelines and is made aware of the procedures for doing so.	Planning focuses on the identification of next steps, along with specific timelines, that will allow the client to draw upon existing strengths to move toward recovery and his or her vision for the future.
Performance and outcome indicators reflect the fact that the desired goal is to promote clients' growth, independence, and wellness; goals that sometimes involve taking reasonable risks that may result in interim setbacks.	The agency offers to host local, regional, state, or national events and advocacy activities for people in recovery and their loved ones.	An orientation to services for new clients includes responsibilities and policies for entering and exiting care.	Services are provided in a person's natural environment whenever possible (home, community, workplace).	Every effort is made to involve significant others and other natural supports in the planning of a person's care, if so desired.
Staff help people get involved with activities not directly related to mental health care.				Procedures are in place to facilitate referrals to other programs and services if the agency cannot meet a person's needs.

Source: *Practice Guidelines for Recovery-Oriented Behavioral Health Care*, by J. Tondora, & L. Davidson, 2006, New Haven, CT: Connecticut Department of Mental Health and Addiction Services.

RSA Discussion Guide

After completing the RSA, answer the questions below and discuss as a group.

Which items on the RSA stand out to members of your team, either because they have already been achieved or because they seem particularly difficult to achieve?	
Which of the five RSA domains are currently most of interest to your organization (e.g., Involvement, Life Goals)?	
What strengths have you identified from items on the RSA that you can build on in your ongoing transformation efforts?	
To what degree, and in what ways, is agency leadership engaged in, promoting, and supporting the transformation process as a whole?	
How is agency leadership currently communicating its vision of resilience and recovery-oriented transformation to staff?	
What is agency leadership doing to cultivate the sense of urgency that Kotter emphasizes or Cohen outlines?	
Which additional leaders, if any, need to be engaged in the process?	
In what ways does your agency's culture still need to change in order to more fully promote resilience and recovery and support the work of peer staff?	

Are there ideas from the RSA and Group Discussion that you can act on?
Identify two or three changes that you can make or ideas that you can put into action.

STRATEGY 1
Why this strategy? What do you hope to achieve?
What strengths currently exist in your program relative to this strategy?
What challenges/obstacles might you encounter as you attempt to implement this strategy within your organization?
STRATEGY 1 DETAILS a. Action Steps b. Timeline c. Internal/External Resources d. Implications for staff? What will staff have to do differently? e. How will you know that you are successful? What will be different?

continued

STRATEGY 2

Why this strategy? What do you hope to achieve?

What strengths currently exist in your program relative to this strategy?

What challenges/obstacles might you encounter as you attempt to implement this strategy within your organization?

STRATEGY 2 DETAILS

a. Action Steps

b. Timeline

c. Internal/External Resources

d. Implications for staff? What will staff have to do differently?

e. How will you know that you are successful? What will be different?

continued

STRATEGY 3
Why this strategy? What do you hope to achieve?
What strengths currently exist in your program relative to this strategy?
What challenges/obstacles might you encounter as you attempt to implement this strategy within your organization?
STRATEGY 3 DETAILS a. Action Steps b. Timeline c. Internal/External Resources d. Implications for staff? What will staff have to do differently? e. How will you know that you are successful? What will be different?

RSA Activity Debriefing

All staff should report out on their identified strategies and immediate next steps.

1. STRATEGY

IMMEDIATE NEXT STEPS

2. STRATEGY

IMMEDIATE NEXT STEPS

3. STRATEGY

IMMEDIATE NEXT STEPS

Ethical Guidelines Activity Facilitator's Guide

INTRODUCTION

Explain that you are going to begin an organization assessment with some self-reflection exercises to help identify small changes that may impact the people receiving services. The potential for harm is present in all health and human service roles, and peer support roles are characterized by unique complexity. Peer staff do not have the natural boundaries that the walls of an agency provide. Navigating relationships out in the community can introduce more nuanced challenges. For instance, how should peer staff respond when the people they support attend the same AA meetings that they attend for their own personal wellness, or when someone they are supporting invites them to join them at a social event as a friend? This activity will help us explore some of the ethical dilemmas peer staff face and provide a model for ethical decision making.

PURPOSE

To explore some of the ethical dilemmas peer staff face and encourage staff to become familiar with using a model of ethical decision making; create clarity and shared expectations around ethics and boundaries

MATERIALS

Ethical Guidelines Activity and Discussion Guide, markers, and newsprint

TIME

1–2 hours

DIRECTIONS

Provide each participant with the Ethical Guidelines Activity, Four Dilemmas, Intimacy Continuum, and Activity Debriefing form. Allow 10–15 minutes to read the four dilemmas and to mark responses using the resources provided in the activity. Allow 25–45 minutes for group discussion. The facilitator should ask the three questions explained in the activity to encourage discussion. The Intimacy Continuum is an additional exercise and provides an opportunity for staff to note dilemmas they may have heard about or witnessed.

WRAP UP

At the end of the exercise allow additional time for debriefing. Staff should discuss any changes in their thinking, as well as any issues they may need to discuss with their supervisors.

Tip

As your agency considers the nature of the boundaries appropriate for community-based work with a diverse population, it may be helpful early in your implementation process to invite both clinical and peer staff to participate in exercises together to clarify expected boundaries and ensure that everyone has a clear and common understanding of what is appropriate in different contexts.

Ethical Guidelines Activity

A model of ethical decision-making is a guide to sorting through the complexity of a situation and an aid to determining the best course of action that one might take in that situation. We propose that those providing recovery support services ask three questions to guide their decision making:

1. Who has the potential to be harmed in the given situation, and how badly would they be harmed?
2. Are there any core recovery values that apply to this situation, and what course of action would these values suggest be taken?
3. What laws, organizational policies, or ethical standards apply to this situation, and what actions would they suggest or dictate?

QUESTION 1

Who has the potential to be harmed in the given situation, and how badly would they be harmed?

To answer this question, assess the vulnerability of the parties listed in the table below and determine the possible severity of harm to each. Where multiple parties are at risk of moderate or significant harm, it is best for peer staff to avoid making the decision alone, and to seek consultation with others, especially a supervisor.

Vulnerable Party	Risk of Significant Harm (√)	Risk of Moderate Harm (√)	Risk of Minimal Harm (√)	No Risk of Harm (√)
Individual/family being served				
Peer staff				
Service organization				
Recovery support services field				
Image of recovery community				
Community at large				

continued

QUESTION 2

Check any core recovery values that apply to this situation, and what course of action these values suggest.

- ☐ Gratitude & Service (Carry hope to individuals, families, and communities.)
- ☐ Recovery (All service hinges on personal recovery.)
- ☐ Use of Self (Know thyself; be the face of recovery; tell your story.)
- ☐ Capability (Improve yourself; give your best.)
- ☐ Honesty (Tell the truth; separate fact from opinion; when wrong, admit it.)
- ☐ Authenticity of Voice (Accurately represent your recovery experience and role.)
- ☐ Credibility (Walk what you talk.)
- ☐ Fidelity (Keep your promises.)
- ☐ Humility (Work within the limitations of your experience and role.)
- ☐ Loyalty (Don't give up; offer multiple chances.)
- ☐ Hope (Offer living proof; focus on the positive.)
- ☐ Dignity and Respect (Express compassion; accept imperfection; honor potential.)
- ☐ Tolerance ("The roads to recovery are many.")
- ☐ Autonomy & Choice (Recovery is voluntary; it must be chosen.)
- ☐ Discretion (Respect privacy; don't gossip.)
- ☐ Protection (Do no harm to and protect self and others; avoid conflicts of interest.)
- ☐ Advocacy (Challenge injustice; be a voice for the voiceless; empower others.)
- ☐ Stewardship (Use resources wisely.)

QUESTION 3

What laws, organizational policies, or ethical standards apply to this situation, and what actions would they suggest or dictate?

The following vignettes explore a variety of ethical dilemmas and demonstrate how this framework can be used to guide decision making.

ETHICAL DILEMMA: CHOICE/AUTONOMY

Charise works as a recovery coach in a women's program that is known for its assertive—some would say aggressive—style of outreach to women referred from the child welfare system. The women Charise attempts to engage in treatment and recovery support services are very ambivalent in the early stages of engagement—not wanting to see her one day, thrilled to see her the next.

The questions are: When does "no" really mean no? What is the line between assertive outreach and stalking? How do we reconcile a person's right to choose with the knowledge that volitional will is compromised, if not destroyed, through the process of addiction?

The ethical tension here is between the values of autonomy and choice versus paternalism and outright domination. What complicates any resolution of this tension is the fact that we are working with people who by the definition of their illness (addiction) have compromised capacities for free choice, leaving the recovery coach (RC) questioning whose free choice they should listen to—Dr. Jekyll's or Mr. Hyde's. In short, what do we do with someone who one moment wants recovery and the next minute wants to get high? The answer is to jumpstart motivation for recovery where little exists, and to guide people through the early stages of recovery until they can make choices that support their own best interests. At a practical level, this means that "no" ("I don't want you to contact me anymore") has to be said several times to different people on different days before we give up on someone (for the time being). If after a reasonable period of time, the answer is still "no," then we disengage with the assurance that we will be available in the future if the person should CHOOSE to call us. The proposition that recovery is voluntary means not only the freedom to choose different pathways of recovery but also the freedom to choose not to recover.

ETHICAL DILEMMA: CHOICE/AUTONOMY

Roberto has been assigned as a peer staff for Oscar, but four weeks into this process, Oscar requests a change in peer staff on the grounds that he is having difficulty relating to Roberto. Do those receiving peer support services have the right to select their own peer staff?

Mismatches in the assignment of peer staff are inevitable, just as mismatches occur in the assignment of counselors. A match between a peer staff member and someone whom he or she serves may be even more important because of the increased time spent together and the potential duration of the relationship. The occasional mismatch is best acknowledged early and resolved either through alterations in coaching style or through reassignment to a different peer staff person. The effects of peer support services result from personal influence, not from any power or authority ascribed to the role. An essential principle of peer-based recovery support services is that those receiving the service ultimately get to define who qualifies as a "peer." Evaluating and resolving potential mismatches is an integral part of good supervision. It is also important that peer staff be supported through these situations.

continued

ETHICAL DILEMMA: DEVELOPING A FRIENDSHIP IN A PEER SUPPORT RELATIONSHIP

Raymond volunteers as a recovery coach for a recovery community organization (a freestanding organization that provides recovery support services unaffiliated with any treatment organization). Raymond has a lot in common with Barry, a person Raymond has been assigned to serve as a recovery coach. Over a period of months, Raymond and Barry have developed quite a friendship and now engage in some social activities (e.g., fishing) together beyond the hours in which Raymond serves as Barry's recovery coach. Are there any ethical issues raised by this friendship?

Friendships may develop within the context of recovery coaching, but there is one thing that distinguishes the recovery coach relationship from other social relationships, and that is the service dimension of that relationship. This means that recovery-coaching relationships are not fully reciprocal, whereas friendships are. The RC has pledged that the focus of the RC relationship is on the needs of the person being coached. In that light, ethical problems could arise if (1) the friendship were initiated by Raymond to meet his needs and not Barry's needs, (2) problems in the friendship interfered with Raymond's ability to provide effective coaching services, or (3) the friendship with Raymond prevented Barry from developing other sobriety-supportive relationships within the recovery community and the larger community. RC relationships will, by definition, be less hierarchical and more reciprocal than relationships between an addiction counselor and his or her client. It is not that one boundary demarcation is right and the other is wrong; what is important is that boundaries are maintained that are role-appropriate. In other arenas of peer-based services, their effectiveness has been attributed in great part to the lack of professional detachment and distance (Fox & Hilton, 1994). Where a developing friendship is getting in the way of effective RC services, it is the responsibility of the RC to raise this concern with his or her supervisor. It may be necessary for the RC, the supervisor, and the person being served to review the situation together. One potential option is to assign and transition the person being served to another RC to avoid potential problems stemming from the dual relationship.

continued

ETHICAL DILEMMA: SEXUAL EXPLOITATION

You supervise recovery coaches for a local recovery advocacy and support organization. It comes to your attention that Joshua, one of your RCs, is sexually involved with a person to whom he is delivering recovery support services. What are the ethical issues involved in this situation? How would these issues differ depending on (1) age or degree of impairment of the person receiving services, (2) whether this was a person currently receiving or a person who had previously received recovery support services, and (3) the time that had passed since the service relationship was terminated? Would you view this situation differently if the relationship were not with the primary client but with a family member or friend who was involved in the service process? Could the recovery coach or the agency face any regulatory or legal liabilities related to this relationship?

The RC service relationship is not a relationship of equal power. The vulnerability of those seeking RC services and the power of the RC role offer situations in which an RC might exploit service relationships for his or her personal, emotional, sexual, or financial gain. It is that power discrepancy that makes intimate relationships between RCs and those with whom they work with ethically inappropriate. The harm that can come from such relationships spans injury to the person/family being served (emotional trauma, severance of services, resistance to seeking future services), injury to the reputation of the RC, and damage to the reputation and financial solvency of the service organization (via litigation against the organization for improper hiring, training, supervision, etc.). The prohibition against an intimate relationship between an RC and service recipient also extends to members of the service recipient's family and intimate social network who are involved in the service process. As for relationships with people who previously received RC services, agencies may define a period of time (mostly in the two-year range) in which such relationships would still be improper. The key here is to evaluate situations that might arise based on the issue of exploitive intent. For example, an RC might be involved with an individual he or she met within the recovery community, and who, he or she discovers, once received RC services from the RC's organization. The RC did not work at the organization at the time, never served as the person's RC, had no initial knowledge of the person's status as a service recipient, and did not use the influence of his or her RC role and organizational affiliation to initiate the intimate relationship. In short, in such a case, there would be no exploitive intent.

Recovery Coaching Intimacy Continuum

Referencing the three questions for ethical decision making, mark your response to the listed recovery coach behaviors. Fill in the blanks with some of your own examples that have occurred or may arise in your organization.

Behavior of Recovery Coach in Recovery Support Relationship	Zone of Safety (always okay)	Zone of Vulnerability (sometimes okay; sometimes not okay)	Zone of Abuse (never okay)
Giving a gift			
Accepting a gift			
Lending money			
Borrowing or accepting money			
Giving a hug			
Saying "You're a very special person."			
Saying "You're a very special person to me."			
Extending or accepting an invitation to a holiday dinner			
Having a sexual relationship with mentee			
Having a sexual relationship with a mentee's family member			

Source: White et al., 2007.

Ethics Activity Debriefing

1. AS A RESULT OF COMPLETING THIS ACTIVITY AND LEARNING MORE ABOUT ETHICAL DECISION MAKING, HAVE THERE BEEN ANY CHANGES TO YOUR THINKING?

2. ARE THERE ANY TOPICS THAT YOU WOULD LIKE TO DISCUSS FURTHER WITH YOUR SUPERVISOR?

Assessing Role Clarity and Readiness for Integrating Clinical and Peer Support Staff

Consider the following set of questions to assess how prepared your agency is for the process of integrating peer and nonpeer staff and services and supports:

1. What does your team plan to do, or what have you already done, to ensure that peer staff working within your agency have an opportunity to provide peer support (rather than other duties that may be viewed as more critical, such as transportation assistance, administrative functions, etc.)?

2. What are the unique aspects of the roles of peer staff that could not be performed by other staff?

3. What tasks to be performed by peer staff are already being performed by existing nonpeer staff? Are there reasons to reconsider this area of overlap?

4. Are there any activities or responsibilities that you will expect of your peer staff that might compromise their ability to provide peer support effectively?

Module 2 Tools

Practice 2. Involve Non-Peer Staff and Organizational Leaders Throughout the Hiring Process

- Deep Dive: Guidelines for Running a Productive Recruiting and Hiring Committee

Practice 3. Write a Detailed Job Description

- Transformation Center–Parts of a Job Description
- Transformation Center–Sample Peer Staff Function and Responsibility Statements
- Sample Job Description

Practice 4. Define Peer Staff Qualifications

- Points to Consider When Interviewing a Person with a Legal Record

Practice 5. Include People Who Use or Have Used Your Agency's Services in the Hiring Committee

- Wedge Recovery Centers–What Can You Ask?

Practice 7. Ensure that Hiring Staff Understand that Questions Related to Disability Cannot Be Asked During the Interview and Hiring Process

- Interview Questions for Peer Positions
- Horizon House–Certified Peer Specialist Interview Questionnaire
- Comprehensive List of Sample Interview Questions
- Applicant Score Sheet

Practice 8. Use a Range of Interview Formats

- Horizon House–What Would You Do?
- Horizon House–Role Plays
- Screening Evaluation Tool

Practice 12. Ensure that Peer Staff Have Access to Resources

- Peer Access Checklist Facilitator's Guide
- Peer Access Checklist

Practice 13. Understand and Manage Accommodations for Employees with Disabilities

- Deep Dive: Common Questions About Managing Accommodations for Employees with Disabilities

Practice 15. Create a Positive Onboarding Experience

- Sample New Hire Announcement

Deep Dive: Guidelines for Running a Productive Recruiting and Hiring Committee

ESTABLISH A FORMAL SELECTION COMMITTEE

- Establish a reasonably sized committee based on the size and needs of your agency and hiring efforts. This size of the committee is important, because a committee that is too large will make scheduling meetings and interviews more difficult, which might slow down the recruiting and hiring process. On the other hand, a committee that is too small might be unable to function if at any given time one or two members are unable to participate.
- In forming the committee, make sure to have as much diversity as possible. Consider diversity in age, race, gender identity, amount and type of education, length of time with the organization, etc.
- Include an individual currently receiving services or program alumni.
- Include the staff member(s) who will be supervising peer support staff.
- A member of Senior Leadership should be involved with the committee as a member or an executive sponsor.
- Include staff who are grounded in recovery values and have a clear understanding of peer support roles and expectations. If you have staff who are grounded in recovery values but may not have experience with or training in peer staff roles, consider providing an information session or training to help them obtain a clear understanding.
- Invite staff who are well respected and influential individuals within your organization.
- Consider the opinion leaders within your organization, and individuals who are generally able to "rally the troops."
- Even if someone who meets these criteria is not the most "positive" member of your staff, including and influencing that individual might be instrumental in gaining the buy-in of other staff members on whom they may have a good deal of influence.
- Ensure that all committee members have full understanding of the commitment and expectations associated with committee membership, and that their participation has prior supervisory approval.

ESTABLISH A PROCESS FOR COMMITTEE MEETINGS AND ACTIVITIES

Reserve several blocks of time on selection committee members' calendars as early as possible to leave ample room for multiple planning and operational meetings. Establishing a reoccurring meeting schedule is extraordinarily helpful in ensuring that these meetings take place regularly and that people are available to attend.

The First Meeting

The first meeting will set the tone for the overall process and shape committee members' attitudes toward their roles and participation. It is important to put the appropriate amount of time and intention into planning this meeting.

The goal of the first meeting is not only to lay the groundwork for the committee's goals and strategies, but also to help committee members understand that their participation is important and valued. This understanding is instrumental to fostering a strong commitment to making time for the meetings and the associated tasks that will take place outside of the meetings. It is essential that committee members feel that attending the

meetings will be a good use of their time and that their presence there will make a difference. Some tips for achieving this include:

- Create a realistically timed agenda and send it out to the committee at least a day in advance. This gives members time to process and think about the agenda items.
- Include a discussion of roles and expectations of the committee members. This includes presenting and discussing expectations around meeting attendance, purpose of the committee, concrete functions of the committee and their role in it, etc. Be realistic about the amount of time and effort that will be required of committee members.
- Begin the meeting by reviewing the agenda and confirming your commitment to sticking to it.
- If you have to deviate from your agenda or extend the meeting longer than scheduled, acknowledge it and give a reason (e.g., "I know we spent more time on this topic than we had planned, but I thought the discussion was important and didn't want to cut it off.") so that your committee members understand that their time was well spent.
- End your meeting on time, so that all committee members are present for the entire discussion and feel that their time is valued and respected.
- Ensure that you end the meeting with clear next steps, expectations, and roles.
- Document the discussion and next steps in the meeting minutes and send those minutes out to the group within a reasonable amount of time following the meeting.

Ongoing Meetings

Conclude your meetings by assigning specific, quantifiable tasks to committee members. For example, each committee member could be asked to identify or contact a specified number of sources who can refer you to potential candidates, to suggest a certain number of venues for posting job announcements, to review a specified number of applications, etc. Continue sending meeting minutes to committee members detailing the discussions that took place in the meeting and their assigned tasks.

Before your next meeting, send committee members an email reminder of their assigned tasks, so they know they are expected to follow through and to report on their activities at the next meeting.

If you notice that a member of the committee does not speak at all during the meeting, you might speak to them afterwards and mention that you are grateful that they are donating their time. Ask them if they feel comfortable in the meeting and if there is anything you can do to facilitate their participation. This may be particularly important if your committee has an alumnus or individual currently receiving services who may be intimidated at the thought of speaking in a room full of staff.

Send meeting reminders out a few days before the next meeting.

COMMITTEE RESPONSIBILITIES

The Recruiting and Hiring Committee has three essential responsibilities: recruiting, screening, and interviewing.

Recruiting Candidates

Responsibility: To conduct candidate outreach through community presentations, social media engagement, online and print advertisements, flier creation and distribution, individual and event-based networking, etc.

Tasks:

- Create talking points or a script that committee members can use to begin the recruitment process.
- Establish a process for documenting and communicating how, when, and where outreach was conducted.

Although you may already have a few ideas about where you will be recruiting (e.g., peer-run organizations, alumni, colleges and universities, peer support training sites), the process of involving the group is invaluable. It strengthens the group and often generates new ideas. A broad pool of possibilities is generated by a broad group of people. Actively involve all committee members in discussions and search options for outreach. You will need assistance from every member of the committee, and the more work the committee does, the less you have to do!

Try to make sure that each member of the committee feels involved, valued, and motivated to play a significant role in recruitment. One technique is to incorporate at least one exercise in which you ask for a contribution from each committee member. This might be a brainstorming session about venues/people/organizations to contact to help identify and recruit candidates. The use of a Nominal Group Technique exercise can be valuable here.

- Ask committee members to take a moment to think about silently mechanisms or places for outreach.
- Give the group a few minutes to think about this, and instruct group members to write down their ideas.
- Once the group has had a few minutes to generate ideas and write them down, have each group member share their ideas.

This activity ensures total group participation and neutralizes the risk that extroverted members might drown out the introverted members who have come up with great ideas.

Another technique to employ is asking if there are any more comments before moving on from a topic, or specifically asking members who have not spoken if they agree with the conclusions or have anything to add. Be sure to do this in a way that implies that you are asking because the committee values their opinions. Take care not to embarrass them or to imply that they need your help to be heard.

Screening Candidates

Responsibility: To conduct initial screening of all applicants. Consider having a core selection of two to three individuals responsible for oversight of the initial screening process.

Tasks:

- Review and screen resumes and writing samples.
- Conduct the initial phone interview to perform final screening prior to bringing candidates in for in-person interviews.
  - Congratulate candidates for making it past the initial screening.
  - The phone interview should serve as a screening for any questions related to the resume, education, experience, etc.
  - The committee member conducting the phone interview should also confirm that the candidate would be able to perform the basic functions of the job (for instance: community-based work, self-disclosure, access to transportation, facilitating groups, public speaking, time management, using technology, etc.)
  - To help make the process of clarifying the application simpler, the screeners should ask one or two open-ended questions, followed by yes-or-no questions.

It is important to note that standard candidate screening criteria may not apply to this position. For example, even people in successful long-term recovery may have pre-recovery histories that include short-lived jobs and long periods of unemployment, previous work experience that is inconsistent with current job functions, and involvement with the criminal justice system.

Interviewing Candidates

Responsibility: To organize and conduct panel interviews of candidates.

Tasks: Organize and schedule panel interviews with candidates who made it through the initial screening process.

A panel interview is one in which at least three people are present to interview a candidate. The purpose of a panel interview is to have diverse perspectives and input into the hiring process and recommendations. It also showcases the ways in which individuals interact with multiple people and reveals their levels of flexibility in communication and their rapport-building skills.

Facing numerous interviewers may be intimidating for candidates, so we recommend keeping the panel to five or fewer interviewers. Standard interview questions should be crafted in advance to facilitate comparisons among candidates and to keep the interview on point. It is also recommended that interviewers ask the same questions to each candidate. When candidates offer information about questions that are not on the interview list, the panel will have to decide whether it is legal and relevant enough to pursue before returning to the formal questions.

Take care not to leap to conclusions based on a candidate's subjective answers. For example, if someone cites a particular strength, this does not mean they perform well in this area, nor does their described weaknesses mean they do it poorly. It is impossible to measure—and often impossible even to guess—what someone means in a subjective description of quality, or whether or not the individual is capable of assessing quality accurately.

Also use caution about making inferences. For example, if candidates say they have a home computer, that does not mean that they are computer literate, just as the fact they do not have a home computer mean they lack computer skills.

It is recommended that the all committee members participate in all interviews. Discuss beforehand what to do if a committee member misses an interview. For example, will other committee members take extensive notes for briefing? Does the committee member who missed the session withdraw from further participation? Do committee members share their feedback on the candidates they interviewed but refrain from participating in actual recommendation/decision-making?

Be sure to send a follow-up email or letter to all interviewees, thanking them for their time and informing them of the next steps.

MAKING A HIRING RECOMMENDATION

The Hiring Committee should determine if the recommendations should be based on a voting, consensus-building, or scoring process. Once all interviews have been completed, the panel interviewers should meet to discuss the candidates. It would be helpful to discuss strengths, concerns, and possible training needs for each applicant.

The final recommendations should be provided to the entire hiring committee, with clear justification as to why the individual or individuals were recommended.

HIRING DECISION DISCUSSION (AFTER HUMAN RESOURCES COMPLETES THE REFERENCE CHECK)

The hiring committee should determine how the final hiring decision will be made. For example, will it be determined by one person (such as the hiring supervisor or program director), or will it be decided by group vote or consensus? These processes should be established by the Hiring Committee early in the search and should be consistent with the organization's HR hiring processes.

Orienting HR staff to the role and function of the peer support staff may be helpful, as this may be the HR department staff's first experience with peer support roles.

NEW HIRE ANNOUNCEMENT & WELCOMING

All staff should be made aware of the new hire via email, newsletter, etc. The content of the message should stress the importance of this position, celebrate the person's strengths and experiences, and clarify what his or her role will be.

It is important to make sure that this practice is in place for all new hires. Sending out a peer support staff member's new hire announcement to all staff when no such announcements have been made regarding other staff members' arrival could actually be counter-productive, fostering confusion and resentment rather than a welcoming environment.

Once hired, each new staff member should participate in a meet-and-greet with other staff members. This might be at an all-staff meeting, or the supervisor might walk the individual around and introduce him or her to other staff members.

Modeling and shadowing different staff members and units help the new hire understand program culture and operations.

Sources: The guide includes content adapted and reproduced with permission from WISELI: Women in Science and Engineering Leadership Institute® at the University of Wisconsin – Madison. It is based on Fine, Eve and Jo Handelsman. 2012. *Searching for Excellence and Diversity*. Madison, WI: University of Wisconsin–Madison, WISELI.

Transformation Center – Parts of a Job Description

A job description provides a summary of the primary duties, responsibilities, and qualifications of a position. It is important to reflect priorities and current expectations.

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 will give, indicating the specific job titles of the supervisors and the positions supervised.

RESPONSIBILITIES

List four to six 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 support provider, or recovery status (e.g., "Self-identify as a current or former user of mental health or co-occurring services who can relate to others who are now using those services"; or "Must be a self-disclosed individual with a mental illness).

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).

Source: L. Legere and P. Nemec, 2011; edited by Achara Consulting.

Transformation Center – Sample Peer Staff Function and Responsibility Statements

SAMPLE FUNCTION STATEMENTS

- Provide vision-driven hope and encouragement, support people in their recovery, and assist them in connecting to the community.
- Provide opportunities for individuals receiving services to direct their own recovery process (self-determination) and act as an advocate for persons served.
- Work with individuals one-on-one and in groups to provide recovery training and outreach to individuals who use mental health services in the community.
- Share personal recovery experiences and develop authentic peer-to-peer relationships.
- Offer instruction and support to help people develop the skills they need to facilitate their individual recovery.
- Inform people served of available service options and choices while promoting the use of natural supports and resources within the community.
- Provide peer mentoring and support for individuals with psychiatric disabilities and receiving mental health services.
- Assist individuals in navigating the mental health services system and in achieving resiliency and recovery as defined by the person.

SAMPLE RESPONSIBILITY STATEMENTS

- Assist in the orientation process for persons who are new to receiving mental health and/or co-occurring disorders services.
- Educate and engage individuals in the Wellness Recovery Action Plan process as a means to recognize early triggers and signs of relapse, and use of individual coping strategies as an alternative to more restrictive services.
- Proactively contact individual to ensure he or she is making a successful transition to community integration and is continuing their progress toward recovery goals.
- Support the individual in seeking to connect/reconnect with family, friends, and significant others and in learning how to improve or eliminate unhealthy relationships.
- Provide education and advocacy within the community that promotes awareness of psychiatric disorders while reducing misconceptions, prejudices, and discrimination.
- Keep treatment team informed about individual's strengths, accomplishments, and obstacles in relation to their recovery goals.
- Complete all required documentation in a timely, legible manner.
- Educate professional staff about the recovery process and the damaging role that stigma can play in undermining recovery.
- Visit community resources with people using services to assist them in becoming familiar with potential opportunities.
- Facilitate the transition from a professionally directed service plan to a self-directed recovery plan.
- Model personal responsibility, self-advocacy, and hope by drawing on one's recovery story, as appropriate.
- Ensure confidentiality of individual information.
- Assess emergency situations, notify supervisor and/or appropriate clinical and administrative personnel of actual or potential problems.
- Exhibit a nonjudgmental approach, effective listening, good eye contact, and positive interactions.

Source: Job descriptions and materials collected by P. Swarbrick and P. Nemec, 2011, The Transformation Center (Boston, MA), and Collaborative Support Programs of New Jersey. Edited by Achara Consulting.

Sample Job Description

GENERAL DESCRIPTION

As an active, engaged member of _____'s _____ team, the peer support staff provide hope, encouragement, and recovery support services to a diverse population of program participants who have a range of behavioral health conditions and are at various stages of recovery. Drawing significantly on personal experience with and knowledge of local behavioral health services and other recovery resources, the peer staff help link individuals receiving services to community resources as directed by that individual's own recovery journey.

The peer support staff work closely with program intake staff, clinicians, social workers, and outreach staff. Peer support staff report directly to the _____.

ESSENTIAL RESPONSIBILITIES

Support Participant Recovery Goals

- Assist in the orientation process for persons who are new to receiving mental health and/or co-occurring disorders services.
- Enroll members into programs and services by effectively communicating their value.
- Develop service plans and guides with members and providers that include health management goals.
- Engage members to achieve health management goals through the use of recovery coaching, motivational interviewing, and problem solving techniques.
- Assist members in overcoming any barriers to meeting recovery goals and update service plans accordingly.
- Assist members in scheduling appointments and accessing community resources.
- Arrange for or directly provide member transportation to recovery and wellness services appointments.
- Accompany members as indicated to recovery and wellness services appointments. This may include transporting mothers and their infants to postpartum appointments.
- Follow up with members via phone calls, home visits, and visits to other settings where members can be found.
- Work with individuals one-on-one and in groups to provide recovery training and outreach to individuals who use mental health services in the community.
- Share personal recovery experiences and develop authentic peer-to-peer relationships.
- Keep accurate and timely documentation in company database of member activities and interventions.

continued

Sample Job Description *continued*

Support Community Integration of Participant

- Work with facilities to help transition members after discharge to a safe home environment.
- Work with participants to provide effective and efficient service coordination.
- Work with social service agencies to arrange to meet other participant needs (housing, food, clothing, financial assistance, etc.).
- Proactively follow up with individual to ensure he or she is making a successful transition to community integration and is continuing their progress toward recovery goals.
- Continuously expand knowledge of community resources, services and programs available to participants and build ongoing relationships with these organizations to advocate for members.

Improve Organizational Service Delivery

- Keep treatment team informed about individual's strengths, accomplishments, and obstacles in relation to their recovery goals.
- Participate in focus groups, hiring committees, work groups, etc. to help shape policies and procedures that benefit program participants.
- Perform other duties as assigned.

Requirements

- High school diploma or equivalent
- Training or certification as a peer support provider
- Willingness to self identify as a current or former recipient of mental health or co-occurring services
- Ability to exhibit a nonjudgmental approach, effective listening, good eye contact, and positive interactions
- Ability to earn the trust of a diverse range of service users, including diversity of age, gender and gender identity, race, religion, sexual orientation, physical and mental ability, and more

Employment Conditions

Work will be performed in a range of professional, institutional, and community settings and may involve some evening, weekend, and on-call hours. Applicants are subject to a background check, and employees may be subject to random drug screens.

Benefits

- Competitive salary
- Health, dental, and vision insurance
- Short-term Disability Insurance
- 401K
- Paid time off, including 8 paid holidays and one floating holiday

Points to Consider When Interviewing a Person with a Legal Record

- How is the conviction relevant to the position the applicant would be filling?
- Was the conviction related to symptoms of mental illnesses or substance use disorders?
- How long ago was the charge?
- How long has the person gone without legal entanglements?
- What is the person doing now?
- Is there any evidence indicating that the applicant has turned his or her life around?
- Is the applicant doing any volunteer work or does he or she have any current references that can be checked?
- How does the applicant talk about their legal history? Does the individual blame others, or take responsibility? In what ways has the applicant changed the way he or she thinks?
- Did the applicant disclose their legal history? Was he or she upfront and honest?
- How does the applicant feel he or she could use the experience to help others?
- Can the applicant describe ways he or she is engaging is self-care or using a support network?

Wedge Recovery Centers – What Can You Ask?

QUESTIONS YOU CANNOT ASK IN AN INTERVIEW

1. How old are you?
2. What is your marital status? Are you married? Single? Divorced?
3. What is your sexual orientation? Are you heterosexual? Homosexual? Bisexual?
4. Do you have a history of drug or alcohol dependence/addiction? Were you treated for your addiction? Do you smoke, drink, or use drugs?
5. Are you a U.S. citizen?
6. Do you have a history of criminal or illegal activity?
7. Do you have any health or medical issues we need to know about?
8. Do you have any disabilities? Are you on SSI?
9. What religion do you practice? Are you spiritual?
10. What is your race?
11. Female candidates: Are you planning on becoming pregnant in the future? If so, how many kids are you planning on having? How soon are you planning on getting pregnant?

QUESTION YOU MAY ASK IN AN INTERVIEW

1. What is your educational background? Where did you go to school? Did you graduate from there/earn a diploma?
2. What is your work experience?
3. Why did you apply for this position?
4. Name three words that would best describe you as a person.
5. What are you looking for from your employer?
6. What style or type of supervision do you prefer?
7. How are you regarding the completion of paperwork/documentation?
8. What are your strengths? What are areas that you need to improve upon?
9. We have many program members in drug and alcohol recovery. Are you familiar with the 12-Step philosophy?
10. Is there any reason you will not be able to fulfill the required job duties for this position?
11. How do you deal with differences? How comfortable are you working with people who do not share your race, ethnicity, religion, or sexual orientation?
12. How comfortable do you feel working with people with:
    - Mental illness
    - Substance use disorder
    - Intellectual disabilities
    - Physical disabilities
    - Alternative lifestyles

If, and ONLY IF, the candidate opens up about his or her own drug and alcohol recovery can you ask how long he/she has been in recovery.

If, and ONLY IF, the candidate has listed his or her criminal background history on the employment application can you ask about it.

Interview Questions for Peer Staff

Peer support staff should bring added value to your organization. The interview process is a vital step in ensuring that the applicant is a good match to the needs of the organization. The questions below may be helpful in exploring these issues.

"LIVED EXPERIENCE" WITH MENTAL HEALTH CONDITIONS

HR departments often have concerns about asking about a person's lived experience due to ADA prohibitions against asking about a person's disability status. The interviewer actually can ask about the person's history when there is a "bona fide occupational qualification." But even without this exception, there are a number of ways to explore this qualification and get other helpful information:

1. Can you tell me some ways that you might use your personal lived experience to support the people you'd be working with? (Ideal responses include ideas around inspiring hope and connecting with people from the place of shared experience. In addition, an ideal response would also include the tools or strategies that the person used to move to a better place.)
2. Tell me about your personal and professional background as it relates to this position. (Responses should include an understanding about the value of bringing "lived experience" to the job).
3. Do you have any life experiences that would make you valuable to this program?
4. What is your experience with the public mental health system? (Peer support staff need more points of commonality with people using services than simply having received a diagnosis.)
5. Do you have any experience working with people who have been diagnosed with a mental health condition? (May bring out volunteer work or other activities not highlighted on the application or resume).
6. What role have peer support staff had in your own recovery? (If a candidate is not familiar with or has not utilized peer support, he or she is probably not a good match for the position.)

EVALUATING PEER SKILLS

7. How would you define a peer support provider, and how would you describe the key role or tasks of a CPS? (Ideally, this would include mutuality, sharing mutual experience, non-expert role, supporting people to become self-determining; inspiring hope, etc. Responses should not be about "making people better," "counseling people," etc.)
8. 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?
9. What do you know about the concept of "recovery?" What is your personal knowledge of recovery, and how did you come to this understanding? (Answer should include mental health recovery, not just 12-step recovery for substance use disorder.)
10. 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 condition, how would you try to support that person? (Responses should include sharing personal experiences, sharing mutual feelings, and sharing tools. Be wary of responses indicating that the applicant would insist that a person's life will get better or offer advice.)

continued

Interview Questions for Peer Staff
continued

11. 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? (Ideal responses may include using the applicant's personal story to demonstrate the experience from the perspective of services users, and facilitating respectful communication among all. An excellent response would include thought about negotiating power and conflict.)
12. Peer support staff 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 (Strong responses may include being able to share my experiences with staff to give them more understanding of the experience from the service user's perspective; sharing alternative approaches from the self-help community that augments the work of clinicians, etc.)
13. Some staff may be apprehensive about or unsupportive of the peer support position. How would you deal with this?
14. If you were in a situation in which you were called to help deescalate a situation with an individual receiving services, how would you respond?
15. A big part of the peer support role is advocating for individuals. You may need to address staff on their approach to working with individuals we serve. Talk about your ability to speak up in difficult or intimidating situations.

ASSESSING WORKER SKILLS

16. This position will require you to work in (identify settings, such as inpatient, emergency room, day treatment, residential, settings in which restraints are sometimes used, and so on). How will your personal lived experience support your work in these settings? (Responses should include peer strategies, even if the person's own experience didn't include the particular setting. If the applicant indicates 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, the applicant would probably not be a good match.)
17. 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?
18. If you felt your job was causing an increase in your stress level, what would you do? (Answer should include seeking supervision, not about going to other staff as a "patient.")
19. Can you tell me about your history of dependability in prior positions or in other activities in your life? (You *can* ask this question; you *cannot* ask about the applicant's history of hospitalizations or history of taking medical leave, or ask when the applicant was "last sick.")
20. Do you function better with the independence to create your own work structure or work better with a clear structure?
21. 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 about working with these people?
22. Have you ever experienced a conflict with a co-worker in the past? How did you handle it? If not, how do you think you would handle it?
23. Other peer support staff have said that the amount of social interaction required for the job can be very draining. Do you have any reaction to this?

Horizon House – Certified Peer Specialist Interview Questionnaire

Candidate Name_____ **Position** _____

Interviewer Name_____ **Interview Date**_____

1. What are your goals and aspirations?
   Explain how this position advances them.
2. Discuss your background.
3. Identify your significant career accomplishments to date.
4. What was your biggest challenge in your last job?
5. Provide an example of a job related problem and how you handled it.
6. What is mental illness?
   How is it best treated in individuals with a chronic condition?
   What conditions are required for a 302 Petition?
7. What are advantages/disadvantages of community work vs. a desk job?
   Identify some safety factors related to this position.
8. What is your familiarity with community resources?
9. Give an example of your organizational skills and ability to juggle priorities.
10. Explain the function of a team and what your role would be.
    What happens when there's disagreement?
11. What were some strengths/shortcomings of your previous supervisors?
    What do you want or need from supervision?
12. What do you do best and how can that be developed and supported?
    Why are you the best candidate for the job?
13. What are the biggest misconception people have about you?
14. Tell me a time that you intervened with a participant that worked, and what you learned from it?
15. Give me another time when your intervention did not work and what you learned from this.
16. When are you available for work? If hired, do you plan to work a second job?
17. Comments:

Comprehensive List of Sample Interview Questions

EXPECTATIONS

1. What are your expectations for this job?
2. What type of work settings motivates you?
3. Why did you apply for this position?
4. Why should you be hired for this position?
5. Based on what you know about the position, which aspects of it would be most attractive to you? Least attractive?
6. What do you think are the most important qualities we should look for in someone to fill this particular position?
7. When is your morale highest at work?
8. What do you know about this organization?

MANAGEMENT ATTITUDES

1. What is the most important function of a manager?
2. What kind of direction do you prefer from a supervisor?
3. Give an example when you challenged a policy that you did not agree with? If you haven't done this, how would you?
4. What do you consider to be important attributes of a supervisor?
5. What kind of supervisor do you enjoy working for most? Least?
6. If you are asked to perform a task that you are not comfortable with performing, how do you handle that?

RECOVERY LEADERSHIP QUALITIES

1. Give an example of a time when you were able to motivate or inspire someone else.
2. Describe a situation in which you were able to positively influence the actions of others in a desired direction.
3. Describe a time when you had to modify your attitude, beliefs, or actions to respond to the needs of another?
4. What is the role of peer support services in the system transformation?

RECOVERY VALUES AND TRANSFORMATION LEADERSHIP

1. What does recovery mean to you?
2. What excites you the most about the transformation?
3. In the last few years, what innovative recovery oriented ideas have you had to improve the service system? Were you able to implement them? How were they innovative?
4. What aspects of your own journey will best be able to inspire and give hope to those you serve?

PROVIDING PEER SUPPORT

1. Please describe how you would initially engage someone.
2. How do you develop trust and a relationship with the people you are supporting?
3. What do you look for or encourage when helping someone create a recovery plan?
4. What steps would you take if the person you were supporting was not making consistent contact?

continued

Comprehensive List of Sample Interview Questions *continued*

5. How would you define the difference between peer support staff, sponsors, case managers, and counselors?
6. Peer support staff will spend majority of their time walking with individuals in the community. This is not a site-based position. How comfortable are you with doing community-based work, outreach, and support?
7. How will you use your personal experience to help others?
8. Do you prefer written, email, phone, or face-to-face communication with folks that you will be supporting?
9. Peer support staff may be asked to participate in presentations and trainings. Describe your experience in presenting to a large group of people. Have you participated in Story Telling Training?
10. Many peer support staff will participate in or co-facilitate groups. Please describe your experience with facilitating group sessions.
11. Peer support staff are advocates for the people they serve. Please describe a situation where you advocated the rights or the needs of another person.
12. Self-disclosure is not only encouraged but expected of peer support staff. Please describe your comfort level and experience with self-disclosure.
13. Historically, many people believed that AA/NA was the pathway to recovery for all people who have a substance use disorder or that people with severe mental illness need to be medicated and attend treatment for the rest of their lives. Today the field is embracing and promoting multiple pathways to recovery. Please describe your views on an individual choosing his or her own path to recovery and, as their peer support provider, what your role would be.

UNDERSTANDING THE WORKLOAD

1. Please describe how you set and measure goals.
2. How do you monitor the progress of assignments and projects?
3. How do you handle a heavy workload with many strict deadlines?
4. You will be expected to work some evenings and weekends; do you have this flexibility?
5. What experiences have you had working as a member of a team? What are the advantages?
6. How would you define effective communication? What skills do you have that makes you a good communicator?
7. You will find that this job is challenging and demanding. All staff are encouraged and supported in maintaining their own wellness. What do you do to maintain your own wellness? How can we/your supervisor best support you when you are feeling overwhelmed?
8. What role do you think your co-workers, supervisors, and agency leaders should have in supporting your personal wellness? What are your expectations for support in the workplace?

EDUCATION AND TRAINING EXPERIENCES

1. Describe the relevant formal learning experiences you've had that will support you in this role.
2. What are your long-term educational and professional goals? How will this work relate to those goals?

Applicant Score Sheet

Applicant Name_____ **Interview Date** _____

Committee Member Name_____ **Total Score**_____

	Poor (1)	Fair (2)	Good (3)	Excellent (4)	Outstanding (5)
Question 1:					
Question 2:					
Question 3:					
Question 4:					
Question 5:					
Question 6:					
Question 7:					
Question 8:					
Question 9:					
Question 10:					
Strengths:					
Concerns:					
Possible Training Needs:					

Horizon House – What Would You Do?

SCENARIO 1. Matching Intensity of Need and Dose of Service and Community-Based Work

A person you are serving presents with high levels of need and requires an intense dose of service. This person is new in recovery and recently completed treatment. You agreed to meet face-to-face at least weekly for the next three months. After three weeks, this person disclosed that they would like to continue working with you but are unable to come to your office to meet weekly, because they began a new job. This job was part of this individual's recovery plan. As this individual's peer support provider, how would you respond? What might you suggest?

SCENARIO 2. Personal Life

David has flourished as a peer support staff member for the past three years, but he is currently going through a very difficult time in his personal life. His mother, whom he was very close to and lived with, has abruptly and unexpectedly passed away. Recently, David has been missing work, has decreased work productivity, and disclosed to his friend concerns for his own wellness. We are all faced with traumatic events throughout life. If you were David, how would you handle this situation? What should David and his supervisor do in response to this circumstance?

SCENARIO 3. Mental Illness

Darrin is a person that you have been supporting for several months. He was diagnosed with bipolar disorder many years ago. Darrin has been seeing you, a therapist, and a psychiatrist. He recently has been acting unusual and missing appointments. When you get him on the phone, he sounds irrational, paranoid, and delusional. You ask your supervisor if you could take a training on bipolar disorder to better understand the condition. What is your role as his peer support provider? What types of questions might you ask Darrin? What else could you be doing to best support Darrin?

SCENARIO 4. Recognizing Someone from Your Past

Tina is greeting people in the waiting room while they are waiting for an intake appointment. When she walks in the room she recognizes a woman from the community. Tina believes it is someone she hung out with off and on while she was active in her addiction. Tina hesitates before she approaches this woman. What should Tina do? Should Tina disclose a pre-existing relationship to the supervisor?

SCENARIO 5. Personal Boundaries

Peer support staff member Linda is very active in her church. Today, a person Linda is supporting mentions the name of a new boyfriend whom Linda recognizes as a member of her church. This man has a reputation for struggling with addiction and is also a well-known drug dealer. She has tried to help him through her church, although he has not been receptive. Should Linda disclose that she knows this man in her personal life? How should she handle this situation?

SCENARIO 6. Trauma/Switching Staff

One of the women you recently began working with has a history of trauma and sexual abuse. She disclosed that she prefers to work with men and be in groups with men. She disclosed that she does not know how to get along with women. This woman has not been committed to the relationship, and when she does attend a group she is very disruptive, rude. She is not even engaged in individual sessions. Despite your best efforts, you and she never really made a strong connection. She recently requested to switch from you to a male peer support provider. What are some concerns in this scenario? How would you handle this situation?

continued

What Would You Do? *continued*

SCENARIO 7. Peer Support

Chris, a peer support staff member in your office, always has his charts complete and documentation up to date. Chris is continually admired by his peers and praised by his supervisors for his excellent documentation and peer support skills. You begin to notice that Chris is showing up later, missing appointments, and does not seem motivated. He is falling behind on his charts and seems discouraged. How would you handle this situation? What issues does this situation present?

SCENARIO 8. Boundaries

Greg has worked as Tom's peer support provider for the past two months, and they have formed a great rapport. Today, Tom asked Greg to attend a family BBQ for his son's birthday this weekend. Tom even suggested some toys his son would like. Greg is unsure how to respond to this invitation. In the meantime, Tom sent Greg a Facebook friend request. As his peer support staff member, he does not want to blur boundaries. What harm and injury (if any) might result from accepting the invitation? What would you do?

SCENARIO 9. Disclosure/Confidentiality

Karen has been in and out of treatment and has an off-and-on-again relationship with you as a peer support provider. She just completed a long-term treatment program and is doing well. Today you run into Shelly, Karen's sister, with whom you partnered with in the past on supporting Karen's recovery plan. Shelly's first comment to you is, "Hey, I have not seen my sister in month's, have you, how is she doing?" She appears happy to see you, but concerned about her sister. How do you respond? Would this be an appropriate disclosure?

SCENARIO 10. Balancing Demands

You are the new peer staff member in the office. You learn very quickly that there is more paperwork and deadlines than you realized. You are beginning to feel overwhelmed by balancing the demands of paperwork and actually working with people. What would you do in this situation? Who do you talk to about this?

SCENARIO 11. Role Clarity

(RC Interview) When meeting with an individual for the first time, they quickly inform you that they do not need a Recovery Coach because they already have a sponsor. How do you respond?

(CPS Interview) When meeting with an individual for the first time, they quickly inform you that they do not need a Certified Peer Specialist because they already have a case manager. How do you respond?

SCENARIO 12. Challenge with Stigma or Discrimination from Colleague

Although most of your co-workers have embraced your role within the agency and welcomed you, there is one co-worker who seems to treat you differently than other staff members do. One day you learn from a co-worker that she told them that you "don't know anything really" because you "don't even have a degree" and are "really just one of 'them' anyway" You also learn that this co-worker thinks you shouldn't be getting paid to provide peer support. How do you respond, both in the moment when you're given this information, and moving forward?

These interview scenarios are designed to be acted in role-play format. The interviewee would take the role of the staff member. The interviewer would prepare the interviewee by describing the scenario approach, but the focus theme would not be identified until after the scenario had been completed. After each scenario, the interviewer would clearly state the role play was over, and there would be a brief discussion about it. This would continue with the five scenarios.

ETHICAL FOCUS

You are a staff member working the 3rd shift, and you notice your co-worker is asleep. What do you do?

Elements to look for in response
The interviewee

- perceives this is a serious concern
- would not leave a staff member asleep while on duty.
- would report their findings to their supervisor immediately.

DE-ESCALATION FOCUS

Staff member is having a quiet conversation with a participant in a crowded community TV room. Another participant who appears agitated enters the room and begins making threatening gestures toward the participant you are talking with. How would you handle the situation?

Elements to look for in response
The interviewee

- has some knowledge of de-escalation techniques.
- can identify the red flags of signaling a potentially explosive escalation of the situation.
- would take appropriate actions.

BOUNDARIES FOCUS

Your usually attend work with a bag of chips and a soda every afternoon. A participant notices that your are busy and do not have your usual bag of chips and soda. The participant insists on buying you a bag of potato chips and soda. How would you handle the situation?

Elements to look for in response
The interviewee

- understands his or her role as an employee.
- understands what boundaries are and why they are essential tool when working with individuals in treatment.
- can communicate this understanding in a non-offensive manner to the participant.

TREATMENT TEAM FOCUS

A participant reveals that she stopped taking her medications, and she insists that you don't tell the other team members. How would you handle this situation?

Elements to look for in response
The interviewee

- understands that all clinical information will be shared with the clinical team who have been trained in the HIPAA regulations, and the staff will assure the individual that they will safeguard personal information.
- will discuss with the individual the purpose for this team effort and the role that the treatment team plays in their recovery.

ABUSE/NEGLECT FOCUS

You observe a co-worker address a participant in a questionable fashion; how do you address this situation? You observe a staff member treating a participant in abusive or neglectful manner, how do you address this situation?

Elements to look for in response
The interviewee

- understands what constitutes abuse or neglect.
- understands he or she has a voice and can hold co-workers accountable for their behavior.
- can identify several means to address the co-workers actions.

Screening Evaluation Tool

RESUME	COMMENTS	YES	NO
Contact Info			
Employment history fits job description (including documentation, use of technology, and working with others)			
Education – minimum of GED or HS diploma			
Relevant trainings and certifications (including peer support training and certification)			
Awards			
Resume displayed basic writing skills (including grammar, spelling, sentence structure, clarity, etc.)			

APPLICATION	COMMENTS	YES	NO
Followed instructions and answered all questions			
Utilized recovery oriented and strengths-based language			
Disclosed being a person in recovery			
Demonstrated basic writing skills			

continued

Screening Evaluation Tool
continued

PHONE INTERVIEW	COMMENTS	YES	NO
Ability to articulate recovery experience			
Clear career goals			
Basic understanding of peer support staff role			
Understanding of agency services and target population			
Comfort level with public speaking			
Access to transportation			
Experience with/attitude about documentation			
Experience with technology			
Knowledge of community resources			

WRITING SAMPLE	COMMENTS	YES	NO
Error free (minimal to no typos, spelling, grammar, or syntax errors)			
Design elements present and consistent (i.e., spacing and font size, bullets, bolding, and so on)			
Content flow is logical and easy to understand			
Presence of recovery-oriented and strengths-based language			

OTHER QUESTIONS	APPLICANT ANSWER
1.	
2.	
3.	
Recommendation:	

Peer Access Checklist Facilitator's Guide

INTRODUCTION

Organizational policies can hinder or facilitate peer support staff's ability to be responsive to the individuals being served. For example, does the organization have resources for bus and train passes, emergency shelter, meals? If so, do peer staff have immediate access to these resources, or do they need to navigate multiple approval processes to, say, secure a bus pass?

PURPOSE

To examine peer support staff access to needed resources and the extent to which organizational policies and procedures facilitate or hinder responsiveness on the part of peer staff.

MATERIALS

Peer Access Checklist (next page); any relevant agencies policies and procedures (i.e., petty cash, referrals) and newsprint with markers

TIME

1 hour

ACTIVITY DIRECTIONS

All peer staff and peer staff supervisors should participate in this activity. One or two individuals should facilitate. Provide each participant with the checklist. A facilitator should read the instructions, purpose and allow a few minutes for staff to review the content. A facilitator should go through each resource one at a time to identify if peer support staff have access to these resources and if yes, what the process is for the peer support staff to be able to provide the individual with the resource. For each resource allow time for groups discussion and if needed reference the current relevant policy and procedure.

WRAP UP

At the end of the exercise, allow time for discussion. Here are a few questions to guide the discussion:

- Are there any resources that we don't have that would help peer staff serve individuals?
- Are any current resources so difficult or time-consuming to obtain that peer staff can't respond immediately to individual needs?
- Are there procedures or policies that inhibits peer staff obtaining any resource? If yes, discuss strategies to remove or reduce the barriers while maintaining accountability.

Peer Access Checklist

ACCESS TO RESOURCE	YES	NO	LENGTH OF PROCESS, FROM PEER REQUEST TO RESOURCE IN HAND
Petty cash			
Clothing closet			
Appropriate interviewing attire			
Food pantry			
Transportation			
Emergency housing vouchers			
Stable housing			
Resources to assist with utilities, rent, etc.			
Expedited access to treatment			
Legal aid or legal support			
Vital documents (i.e., identification/birth certificate/social security card)			
Resources for child care assistance			
Free activities in the community			
Computers or tablets (check email, search internet, complete applications, etc.			
Toiletries and personal care Items			
Support with obtaining medications			
Medical/dental care			
Other:			
Other:			

Deep Dive: Common Questions About Managing Accommodations for Employees with Disabilities

WHAT SHOULD WE DO WHEN PRESENTED WITH THE REQUEST FOR REASONABLE ACCOMMODATION?

Prior to responding to the request, the employer has a right to request documentation of the disability and the nature of its impact on work performance. The important thing to remember is that requested medical documentation should focus not on things such as diagnosis or history of hospitalization, but rather, on (1) the functional limitations of the disability; (2) how these limitations might impact work performance; and (3) recommendations for what types of reasonable accommodations might be effective. While the employer has a right to request such documentation, this can often be avoided by first having an informal and supportive conversation with the employee in order to clarify needs and identify appropriate accommodations. Remember, your best source of information is the employee himself or herself!

HOW DOES REASONABLE ACCOMMODATION APPLY TO PERSONS IN RECOVERY?

Accommodations for persons who use wheelchairs make intuitive sense, it's easy to see the need for wheelchair ramps, handrails, and desk-lifts. But what types of accommodations might benefit a person in recovery from a behavioral health condition? The answer depends on how the person's condition specifically effects his or her functioning and work performance. Examples of things with which people might experience difficulty include the following: screening out excessive stimulation in the environment, sustaining concentration, maintaining stamina over the work day, handling time pressures, or prioritizing tasks. As an employer, there is a range of accommodations you might offer to enable people in recovery to better meet performance expectations. These include allowing late or early arrival to accommodate appointments, offering longer or more frequent breaks, providing task lists in writing, accepting alternative formats for deliverables (e.g., recorded notes instead of written notes), providing access to a partitioned work space or more private work area, allowing use of white noise technology, providing increased supervision, or designating co-worker mentors.

There are extensive public and private resources to help employers design and implement reasonable accommodations. For example, employers can contact the Job Accommodations Network (JAN) free of charge. The Job Accommodation Network is a service provided by the U.S. Department of Labor's Office of Disability Employment Policy. JAN's mission is to facilitate the employment and retention of workers with disabilities by providing employers, employment providers, persons with disabilities, their family members, and other interested parties with information on job accommodations, entrepreneurship, and related subjects. A sample JAN accommodations profile for a person in recovery is provided below:

> *A peer support worker in a social service agency has bipolar disorder. In addition to meeting with her participants, her duties include making telephone calls, writing notes in her participants' health records, and filling out her time sheets. Due to bipolar disorder, she has difficulties with concentration and short-term memory. Due to the*

continued

educational disruptions caused by the bipolar disorder, she also has limited literacy. Her accommodation included assistance in organizing her work and completing her time sheets, a dual headset for her telephone that allowed her to listen to music when not talking on the telephone, and a digital recorder that allowed her to dictate her health record notes. These accommodations minimized distractions and increased concentration, compensated for limited literacy, and relaxed the employee. Also, meetings were held with the supervisor once a week to discuss workplace issues. These meetings are recorded so the employee can remember issues that are discussed and can replay the information to improve her memory.

HOW DO WE HANDLE OTHER EMPLOYEES WHO ASK WHY SOMEONE IS RECEIVING "SPECIAL TREATMENT"?

First, employees should be educated that reasonable accommodations are not considered "special treatment" but are legally mandated modifications to a work environment or role that enable persons with disabilities to have *equal* access to employment opportunities. Once this education is provided, specific, confidential information about a particular employee's disability, medical condition, or accommodation can only be shared on a business necessity basis or with the explicit permission of the employee. Typically, this means involving the person providing or approving the accommodations, those in charge of safety and risk procedures, or those responsible for Equal Opportunity or Affirmative Action. Disclosure beyond this "need to know" circle without the permission of the employee is illegal.

It is true, however, that many of the simple accommodations that work for someone with a behavioral health condition may be desired by his or her co-workers, and this may breed resentment or suspicion. Employers can address this by telling the co-worker that they are acting in accordance with employment laws and that they strive to design supportive work environments that take into account the needs of all employees, while offering to meet with that employee at a later time to discuss his or her personal needs. Many employers with experience providing reasonable accommodations have found that they cost little to implement and significantly enhance work performance. This suggests that, in addition to being required by disability rights legislation, many reasonable accommodations could be a standard part of good business and management practice.

HOW DO WE RESPOND TO INAPPROPRIATE BEHAVIOR ON THE JOB?

Under current employment laws, an employer never has to excuse a uniformly applied conduct rule that is job related and consistent with business necessity. According to the Job Accommodations Network:

> *This means, for example, that an employer never has to tolerate or excuse violence, threats of violence, stealing, or destruction of property. An employer may discipline an employee with a disability for engaging in such misconduct if it would impose the same discipline on an employee without a disability. Furthermore, an employer must make reasonable accommodations to enable an otherwise qualified employee with a disability to meet such a conduct standard in the future.*

Specific to the employment of persons in recovery, it is important to highlight the notion that conduct rules must be "uniformly applied." If an employee with a disclosed behavioral health condition was involved in an inappropriate verbal or physical altercation with a co-worker, is the discipline that is imposed on the person in recovery the same as it has been for other (non-peer) employees in the past? Is it the same for both parties

continued

involved in the current altercation? Or is the employee with the behavioral health condition perhaps expected to comply with counseling through the agency's EAP while others are given only verbal or written reprimands in their personnel file? This would be an example of a conduct policy that is not uniformly applied, and is arguably influenced by inaccurate and discriminatory beliefs regarding the potential for violence among persons with behavioral health conditions.

CAN WE FIRE A PERSON IN RECOVERY IF SHE OR HE IS NOT DOING THE JOB?

Yes. A person with a disability, behavioral health or otherwise, may be terminated if he or she is unable to perform the essential functions of the job. However, the employer is obligated to first make attempts to provide reasonable accommodations in order to enable the employee to meet performance expectations. If there currently are no internal rules or regulations regarding such a process at your agency, it will be important to take the time to discuss developing such policies with your agency's human resources department.

WHAT TYPES OF EMPLOYMENT-RELATED LAWS MAY BE RELEVANT AS WE EXPAND OUR HIRING OF PEOPLE IN RECOVERY?

The *Rehabilitation Act of 1973* was the first "rights" legislation to prohibit discrimination against people with disabilities. The scope of this law, however, was limited to programs conducted or funded by Federal agencies. It did not extend protections to the private sector.

The employment provisions of the *Americans with Disabilities Act (ADA, Title I) of 1990* prohibited discrimination against persons with disabilities in regard to job application procedures; the hiring, advancement, or discharge of employees; employee compensation; job training; and other terms, conditions, and privileges of employment. Title I of the ADA provides extensive guidance for organizations and employers regarding compliance expectations both pre- and post-hire.

The *Family and Medical Leave Act (FMLA) of 1993* provides employees with up to 12 weeks of unpaid leave within a 12-month period, during which their jobs are protected. Job restoration is guaranteed unless the employee is unable to perform the essential functions of the job.

DOES THE ADA APPLY TO PERSONS WITH BEHAVIORAL HEALTH CONDITIONS?

The ADA does not contain a list of "covered" conditions that constitute disabilities. Instead, the ADA has a general definition that each person must meet in order to be considered a "qualified individual with a disability." This definition focuses on whether or not the person is regarded as having physical or mental impairment that substantially limits one or more major life activities, or a record of such an impairment (EEOC, 1992). Therefore, some people with behavioral health conditions will have a disability that is covered under the ADA, and some will not.

Sample New Hire Announcement

[Organization name] and the recruitment and hire committee is delighted to announce that John Deer has accepted the position of Recovery Coach/Certified Peer Specialist.

John will be working as part of the clinical team, reporting to the Program Supervisor. In this role, John will provide a unique array of services to complement, supplement, and benefit clinical services. For example, John will provide assertive outreach, advocacy, recovery and wellness planning, crises support, and post-treatment monitoring, among his other responsibilities. He will provide these supports in partnership with the entire clinical team.

John is certified as a recovery specialist and has partnered with various organizations across the city. He has been a productive member of the OAS Advisory Board and a committed volunteer at PRO-ACT Recovery Community Center. John participated in story telling training and has shared his personal recovery story in various venues. He represents the hope that recovery is possible.

The integration of peer support services marks a milestone for our overall transformation efforts. Early in the transformation process, peer support services provided by persons in recovery from mental health and substance use conditions were recognized as a powerful catalyst for systems change and also as a conduit for enhancing recovery outcomes and the quality of life of individuals receiving services. Peer leadership will continue to play a crucial role as we further enhance our recovery orientation.

Peer leadership will continue to evolve and expand over time. As the peer support role is new for the organization, we hope that you will partner with John in navigating his role and understanding how we can all work together to best serve our community.

Please join us in welcoming John Deer!

Module 3 Tools

Practice 3. Promote Hope, Build Rapport, and Establish Trust

- DBHIDS Storytelling Framework
- DBHIDS Storytelling Tips

Practice 4. Create Safety

- Tips for Creating Safety
- Grounding Exercise Facilitator's Guide
- Grounding Exercise Script

Practice 7. Ensure Your Assessment Tools and Processes are Recovery-Oriented

- Recovery Capital Scale
- Deep Dive: Guidelines for Developing a Strength-Based Assessment

Practice 11. Promote a Culture of Peer Leadership and Support

- Deep Dive: Philadelphia Guidelines for Facilitating Peer-Run Groups and Meetings

Practice 13. Develop a Peer Advisory Council

- Guidelines for Establishing Group Norms for a Peer Advisory Council
- Sample Invitation to become a member of a PAC

Practice 15. Assertively Develop Partnerships With Other Community Organizations

- Elements of a Memorandum of Agreement

Practice 16. Provide Assertive, Responsive Continuing Support

- Menu of Continuing Support Checklist
- Tips for Assertive Outreach or Re-Engagement

Practice 18. Offer Telephonic Recovery Support for Addiction Recovery

- Script for Explaining Telephonic Recovery
- Telephonic Check-In Tool

THREE PARTS OF A STORY

1 BEGINNING

Establish the context of your story.

- Help listeners understand where you came from, what happened to you, what the dark times felt like, and so on.
- Be brief, but offer enough background about what your life was like before recovery.

2 MIDDLE

Share the action you took in your journey of recovery.

- Describe strategies and supports that were helpful.
- Share what has not been helpful to your recovery journey.
- Explain what you did to initiate and then sustain your recovery.

3 END

Share your accomplishments and hopes for the future.

- Describe what recovery has allowed you to become.
- Share what you now aspire to be.

QUESTIONS FOR CONSIDERATION

- Do I want others to know about
  - my difficult time?
  - my feelings during my difficult time?
  - which approaches, attitudes, supports, and resources did not help in my recovery process?
  - which strategies, supports, and resources have helped in my recovery process?
  - how my life has changed in recovery?
  - where I see myself one year, two years, five years in the future?
- Is there a common theme that runs through my recovery story that I want to be sure listeners walk away with?
- Are there key messages that other presenters are sharing that my story can help to reinforce?

PRESENTATION SKILL BUILDING

- Practice ahead of time with a trusted person.
- Be aware of facial expressions and body language, and don't be afraid to smile!
- Don't use technical language or acronyms that your listeners may not know.
- Do use humor when appropriate.
- Be aware of your tone and how fast you talk.
- Make eye contact with the audience.
- Develop a system for staying on track of your allotted time.
- Develop a system for keeping your story organized.

KEEP IN MIND

- Use person-first and strengths-based language.
- Try to stay away from stigmatizing words such as "addict," "alcoholic," "junkie."
- Think of yourself as the hero/heroine in your own story. As Bill White has described it, recovery is a heroic journey. Consider telling your story though this lens.
- You don't need to share more than you're comfortable sharing! Everybody has a different comfort level.
- Sharing your story can leave you feeling vulnerable.
- Be gentle with yourself. Be aware of your emotions and accept them.
- Have a self-care plan and supports in place in case difficult feelings or memories arise.

Tips for Creating Safety

In wellness or recovery processes, people will sometimes benefit from stepping out of their comfort zones and facing emotional discomfort, even anxiety. With the right support, these experiences can help people grow stronger, healthier, and more mature.

However, encounters that expose people to unhealthy risks or that trigger symptoms of past traumatic experiences can leave individuals less stable than before the experience.

It is not usually plainly evident who has had a traumatic experience. It does not always show, or it might appear as defiance or just "not being ready" for change. Peer support providers, like all staff and volunteers, are responsible for doing whatever they can, within the appropriate limits of their role, to

- support people's physical, mental, and emotional safety.
- avoid creating situations that expose individuals—or the peer support—to danger.

Creating mental and emotional safety is an important part of the peer support role, even if it feels like overprotecting people. If fact, psychological safety is often necessary to the success of wellness efforts.

Below are some important things peer staff can do to increase people's psychological and physical safety.

PSYCHOLOGICAL SAFETY

1. **Seek training on trauma-informed peer support services to learn about**
   - resilience, stress, toxic stress, and trauma, and their prevalence in the lives of people with behavioral health issues.
   - the many ways these experiences can affect people.
   - the implications for organizations, individual service providers, and peer support practices.
2. **Become aware of the range of words, actions, and circumstances that might re-traumatize people or trigger symptoms of preexisting trauma, and do your best to avoid those words, actions, and circumstances.**
3. **Work with your supervisor and colleagues to identify any situations in which people might need to be referred for stabilization or trauma-specific treatment, and make a plan for**
   - contacting the appropriate supervisory or clinical staff and following their instructions.
   - telling people about the services that are available and the need for and benefits of those services.
   - supporting people as they connect with the assessment process and the services they need.

Tips for Creating Safety *continued*

4. **Learn the signs that people might show when reminders of past trauma have "triggered" them. In these situations,**
   - use grounding techniques to help individuals return to the "here and now."
   - call on appropriate resources immediately to help them stabilize.
5. **Exercise and model healthy self-care and appropriate boundaries in all your interactions with the people you serve.**
6. **Become aware of the stress and trauma in your own life (past and present) and use all appropriate resources to stabilize and recover from the effects of these experiences.**

PHYSICAL SAFETY

1. **Keep vigilant for safety issues in the lives of the people you serve. For example, stay alert for**
   - **family violence and unsafe relationships**, with an understanding that violence in intimate relationships often grows worse over time and becomes most dangerous when the person being abused shows signs of leaving the relationship.
   - **community violence** that people are exposed to, either in their neighborhoods or in areas they have to cross in their travel to work, school, stores, services, etc.
   - **unprotected sex** (without proper protection from the spread of disease, or from pregnancy in situations where the partners do not want to conceive).
   - **bullying**—at school, at work, in the neighborhood, in the family, or in service settings—with an understanding that adults can be bullied, too.
   - **safety issues** within the treatment setting, including fire hazards; unsafe air quality; conditions that might cause or contribute to injury; the potential for violence among people receiving services or staff; and the potential for sexual harassment, exploitation, or assault by people receiving services or staff.
2. **Study the challenges to your own safety that you might encounter in the communities and families you serve, and make a safety plan with your agency that might include**
   - working in teams of two.
   - making sure you have safe and ready transportation.
   - always carrying cell phones and chargers, and keeping track of cell phone charge and signal availability in the areas you cover.
   - establishing periodic phone check-in times, so people at your agency can seek you out if you fail to call at the appointed time.
   - finding safe locations to meet with individuals within the community.
   - becoming familiar with and learning how to connect with the safety resources in the community, including law enforcement, public safety, domestic violence agencies, community watch groups, anger management classes, and violence intervention and interruption programs.
   - learning self-defense skills and strategies (this doesn't have to be a black belt in karate; it can include simple ways of escaping an attacker).

Grounding Exercise Facilitator's Guide

PURPOSE

To help people control and stabilize their immediate emotional reactions to a situation, a memory, an experience, etc., and to teach them skills that they can use any time to stabilize their reactions. It is an essential tool to have when one is working with someone who has experienced extreme stress or trauma, and it is an important tool for anyone who experiences strong anger or anxiety.

Under stress, people tend to become caught up in the past (in something that happened and all the pain, anger, guilt, shame associated with it) or in the future (in something fearful that might happen or something we fear will not happen). A grounding exercise returns people to the "here and now," where the past cannot haunt them and the future cannot scare them. It helps people calm down.

MATERIALS

Script for leading people through the exercise (example provided)

TIME

2–5 minutes

COSTS

None

DIRECTIONS

People can use this exercise by themselves, or lead others through it, any time they feel agitated, upset, etc., or any time they feel caught up in the past or future.

Early in the peer support relationship, providers take individual through a simple grounding exercise, and offer to teach them to do it themselves. Then may use this tool any time they or one of the individuals they are serving needs to be stabilized. Grounding helps people return to the present by calling attention to

- the basic, everyday physical sensations of sitting in a chair, feeling the air we breathe, feeling our feet on the floor, and
- the sounds that we hear and the things we see around us in the present.

Until they have learned the grounding instructions, peer support providers can use a script to slowly read instructions to individuals they serve. Individuals listening to the script can close their eyes or keep them open, sit in a chair or lean against a wall or a tree—whatever feels safe and comfortable for them.

Peer support providers then offer a copy of the script to each individual and let encourage them to learn it and use it whenever they feel caught up in past experiences or fears about the future, or when they feel overly anxious, guilty, angry, and so on.

Grounding Exercise Script

"Grounding" is one way of breaking free from out-of-control thoughts, feelings, and memories, and returning to the "here and now." It's a good skill to learn, practice, and get used to doing. Practicing this skill can give you more control over your body's stress system. You can also use it to get back in balance when thoughts, feelings, or memories start crashing in on you. You can practice grounding when you're alone and doing nothing else, then use the same skills and techniques when you're in hard situations—or even in ordinary situations. No one will notice, except you might get more quiet and calm. Here are some possible steps:

Get comfortable in your chair, with both feet on the floor. (If you're standing, you can stand with your back to a wall, a strong tree, etc.) You can close your eyes if you're alone or with people you trust who are grounding too, or you can keep your eyes open and rest them someplace neutral.

Notice the support the back of the chair (or the wall) is giving you—on your back, on your seat. Keep feeling that support, and notice any physical sensations it gives you.

Notice your feet, connecting with the ground. Notice any related sensations.

Push a little bit with your feet against the ground, and notice what happens in your body when you feel that extra contact. Now relax your legs (if you're sitting). If pushing against the ground made you feel more comfortable, remember that, so you can use it in the future when you feel uncomfortable.

Check in with your breath without changing the way you're breathing or making an effort to breathe a certain way. Just notice your breath, and follow it as it goes in and out. See if you notice anything about your breathing. When you pay attention to it, does it get deeper or shallower? Notice any physical sensations as you breathe.

If you notice any places in your body that may be feeling tense, just shift your attention to someplace else in your body that's feeling less tense, or even someplace that's feeling calm and relaxed.

Just connect with that place for a while, feeling that calm place in your body. Make a mental note of it, so you can go back there at times when your stress system starts to overreact. If that place in your body still feels calm when your stress reactions start to rise, it might be a good place to remember and focus your attention on.

Let your attention drift like a very slow wave, down from the top of your head, all the way down, past your back, sensing into the support of your chair (or the wall, tree, etc.), all the way down to your feet connected to the ground.

When you're ready, if you closed your eyes, open them and bring your attention back to the room or the scene around you. Notice the people around you (if there are any), the furniture, the walls, the trees, the ground, etc. You might ask yourself to name ten objects that you can see around you. What do you notice in your body when you notice what's around you? Do you feel more or less comfortable?

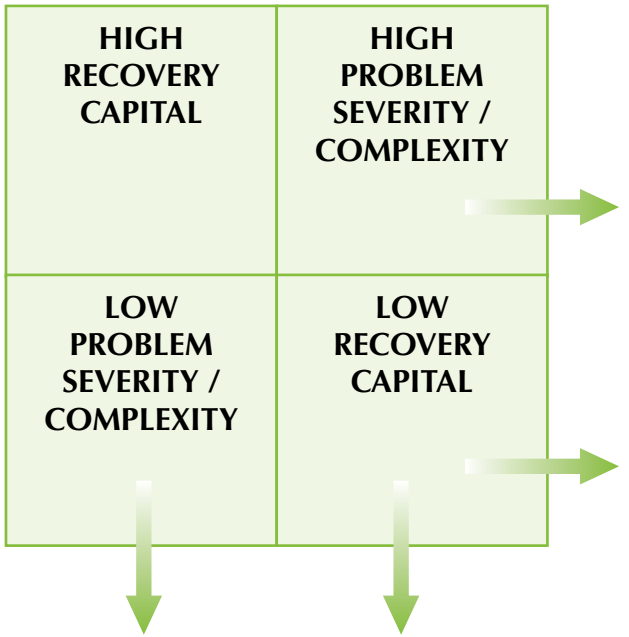
Practice this whenever you can, so you'll remember to do it when things get intense.

There are many possible scripts and formats for grounding exercises. This particular format was adapted from a workshop by Dr. Laurie Leitch and Elaine Miller-Karas, LCSW, Trauma Resource Institute.

Recovery Capital Scale

BACKGROUND

Robert Granfield and William Cloud introduced and elaborated on the concept of "recovery capital" in a series of articles and a 1999 book, Coming Clean: Overcoming Addiction without Treatment. They define recovery capital as the volume of internal and external assets that can be brought to bear to initiate and sustain recovery from alcohol and other drug problems. Recovery capital, or recovery capacity, differs from individual to individual and differs within the same individual at multiple points in time. Recovery capital also interacts with problem severity to shape the intensity and duration of supports needed to achieve recovery. This interaction dictates the intensity or level of care one needs in terms of professional treatment and the intensity and duration of post-treatment recovery support services. The figure below indicates how these combinations of problem severity and recovery capital could differ.



Clients with high problem severity but very high recovery capital may require fewer resources to initiate and sustain recovery than an individual with moderate problem severity but very low recovery capital. Where the former may respond very well to outpatient counseling, linkage to recovery mutual aid groups, and a moderate level of ongoing supervision, the latter may require a higher intensity of treatment, greater enmeshment in a culture of recovery (e.g., placement in a recovery home, greater intensity of mutual aid involvement, involvement in recovery-based social activities), and a more rigorous level of ongoing monitoring and supervision.

Traditional addiction assessment instruments do a reasonably good job of evaluating problem severity and some of the newer instruments improve the assessment of problem complexity (e.g., co-occurring medical/psychiatric problems), but few instruments measure recovery capital. The scale on the following page is intended as a self-assessment instrument to help a client measure his or her degree of recovery capital.

The scale can be completed and discussed in an interview format, or it can be completed by the client and then discussed with the professional helper.

RECOVERY CAPITAL SCALE

Place a number by each statement that best summarizes your situation.

5 = Strongly Agree 4 = Agree 3 = Sometimes 2 = Disagree 1 = Strongly Disagree

___ I have the financial resources to provide for myself and my family.

___ I have personal transportation or access to public transportation.

___ I live in a home and neighborhood that is safe and secure.

___ I live in an environment free from alcohol and other drugs.

___ I have an intimate partner supportive of my recovery process.

___ I have family members who are supportive of my recovery process.

___ I have friends who are supportive of my recovery process.

___ I have people close to me (intimate partner, family members, or friends) who are also in recovery.

___ I have a stable job that I enjoy and that provides for my basic necessities.

___ I have an education or work environment that is conducive to my long-term recovery.

___ I continue to participate in a continuing care program of an addiction treatment program (e.g., groups, alumni association meetings).

___ I have a professional assistance program that is monitoring and supporting my recovery process.

___ I have a primary care physician who attends to my health problems.

___ I am now in reasonably good health.

___ I have an active plan to manage any lingering or potential health problems.

___ I am on prescribed medication that minimizes my cravings for alcohol and other drugs.

___ I have insurance that will allow me to receive help for major health problems.

___ I have access to regular, nutritious meals.

___ I have clothes that are comfortable, clean and conducive to my recovery activities.

___ I have access to recovery support groups in my local community.

___ I have established close affiliation with a local recovery support group.

___ I have a sponsor (or equivalent) who serves as a special mentor related to my recovery.

___ I have access to online recovery support groups.

___ I have completed or am complying with all legal requirements related to my past.

___ There are other people who rely on me to support their own recoveries.

___ My immediate physical environment contains literature, tokens, posters or other symbols of my commitment to recovery.

Recovery Capital Scale *continued*

___ I have recovery rituals that are now part of my daily life.

___ I had a profound experience that marked the beginning or deepening of my commitment to recovery.

___ I now have goals and great hopes for my future.

___ I have problem solving skills and resources that I lacked during my years of active addiction.

___ I feel like I have meaningful, positive participation in my family and community.

___ Today I have a clear sense of who I am.

___ I know that my life has a purpose.

___ Service to others is now an important part of my life.

___ My personal values and sense of right and wrong have become clearer and stronger in recent years.

Possible Score: 175

My Score: _____

The areas in which I scored lowest were the following:

1. _____
2. _____
3. _____
4. _____
5. _____

RECOVERY CAPITAL PLAN

After completing and reviewing the Recovery Capital Scale, complete the following.

In the next year, I will increase my recovery capital by doing the following:

Goal # 1: _____

Goal # 2: _____

Goal # 3: _____

Goal # 4: _____

MY RECOVERY CAPITAL TO-DO LIST

In the next week, I will do the following activities to move closer to achieving the above goals:

1. _____
2. _____
3. _____
4. _____
5. _____

Source: Developed by T. Groshkova, D. Best, & W. White. See: "The Assessment of Recovery Capital: Properties and Psychometrics of a Measure of Addiction Recovery Strengths," *Drug and Alcohol Review* 32(2), 2012, pp. 1–8. Used with permission.

Deep Dive: Guidelines for Developing a Strength-Based Assessment

An assessment is a collection of information about the individual and his or her life, circumstances, and choices that can help feed the planning and service provision process. There are many kinds of tools or instruments (forms) designed to guide this process and collect information. Often a strength-based assessment is organized by "domains," areas or aspects of the individual's life. An example of a set of domains might be:

- Housing
- Employment
- Parenting and/or Reuniting with Children
- Physical Health
- Faith or Spirituality
- Sense of Connection to the Community and Community Supports
- Family and Friends –Support Network
- Hope for the Future

The assessment process accomplishes many important things:

- It informs and supports the wellness/recovery planning process, the provision of recovery support services, and evaluation of the progress people make over time.
- If it is done in a person-centered way, it helps build a sense of trust, connection, and collaboration between the individual receiving services and the peer support provider.
- If it is a strength-based assessment, it gives people a stronger sense of hope, confidence, and motivation to keep going and keep trying.
- If its results are shared with clinical staff, the assessment gives clinicians valuable information that they might not learn in purely clinical assessment and treatment processes.

ASSESSMENT: WHO DOES IT AND WHEN DOES IT HAPPEN?

Assessment is an ongoing process that happens throughout the individual's involvement with peer support services, but it almost always starts with a comprehensive process for gathering as much useful information as possible. This initial assessment might take place in a single long session, or it might be spread out over multiple sessions. Regardless of which approach is used, it is important to keep in mind that the assessment process must continue to grow and change as the service relationship develops.

Depending on your organization's policies and practices, you might be coordinating and integrating your recovery assessment process with those of the clinicians who are doing the clinical assessment process, or you might be doing it separately. There are benefits to integrating these two processes and conducting at least some parts together, so if your organization is receptive to the idea, you might explore the possibility with them. Benefits include

- the insights that peer support staff can bring to the clinical process.
- the emphasis on strength and hope that is a key characteristic of recovery support services.
- higher comfort level for many individual if peer support staff are present during what might be an intimidating or embarrassing process.
- an opportunity for peer support staff to learn about clinical information they might need to know to help people stay safe and emotionally stable.
- an opportunity for the clinical staff to become more familiar with the concept of recovery and how it relates to their own work.

- concrete evidence for the individual access services that he or she is truly part of a larger team organized around his or her well being.

If organizations are concerned about confidentiality, they can always have some portions of the assessments done together and some done separately. If assessment remains an entirely separate process, it will be best if you and the clinical staff meet after you have finished your individual assessment processes, and stay in touch after that, so you can talk about the person you are getting to know and share with one another whatever information is useful and appropriate to share. There should also be a three-way meeting with the clinician, the peer support provider, and the person participating in services. At that meeting, you can all talk about the assessment results and explore how they can help the individual identify priorities.

As the process continues, you will learn more and more about the person participating in services. So it will be important to have regular meetings that combine clinical staff, recovery support staff, and the individual. It will also be important for you to be included in staffing sessions to discuss the person's progress.

COMPLETING THE ASSESSMENT WITH THE INDIVIDUAL

An assessment process can either increase your connection with the individual served or increase the distance between you. Although tools and questions are important, the most important consideration is interpersonal. The person conducting the assessment interview is often asking for personal information from someone who may feel very vulnerable and ashamed. So you need to do all you can to make sure the individual experiences the assessment process as a natural conversation between equals—safe, friendly, strength-based, collaborative and understanding.

TIPS FOR AN EFFECTIVE WELLNESS ASSESSMENT PROCESS

1. Make sure the assessment tools you will be using are compatible with a wellness/ recovery-oriented process. If they are not, some tools are included with this toolkit, and if you explain the benefits of these approaches, your supervisor may be interested in looking at them.
2. Whatever assessment tool you are going to use, become very familiar with it before you conduct the assessment so you can spend as little time as possible reading the questions and as much time as possible making eye contact with the individual and engaging in a natural conversation.
3. Have realistic expectations about the amount of time the assessment process will take. Do not expect to be able to explore all domains of the individual's life in one interview. Make room for multiple interview appointments, leaving enough time for respect, connection, and comfort in each session. It is better to have budgeted more time than you need than it would be to try to rush the process or run out of time.
4. Help people prepare for the service assessment process ahead of time, giving individuals served some information to reflect on before the meeting date, so they can think about their feelings and experiences and be in a better position to contribute to the assessment dialogue. For an example, see "*Getting in the Driver's Seat of Your Treatment: Preparing for Your Plan*."
5. Make sure you have established a relationship of trust with the individual before you begin the assessment process, and honor that relationship throughout the process. For example:
   - Keep all appointments on time, as a sign that you value and respect the individual and his or her time commitments.
   - Confirm in words that you are grateful to the individual for sharing this information with you.
   - Be patient if people hesitate to give certain information, and patient with the fears that make them reluctant to disclose, even if you believe those fears are groundless.

6. Show interest in what the person has to say, and respond in warm and sincere ways. Allow yourself to be absorbed by the process of learning about another human being. It is a privilege to be trusted with information that goes deep in another person's experience, and you can honor and respect that trust.

7. Although you will be using an assessment form, your main job is not to fill out the form during the assessment session. You are there to have a conversation in which the individual can make important discoveries and communicate them in connection with an understanding human being who really wants to hear about them.
   - Make sure the conversation unfolds naturally, and keep in mind your desire to use the discussion process to build and deepen your relationship.
   - Maintain eye contact, and make sure your body is also facing the individual, even if you are required to enter information directly in the computer.
   - Always keep the form (or the computer screen) where the person can see it and remember he or she is working on the form with you, rather than being interviewed or assessed by you. Keep the form or screen angled in the person's direction.
   - Do not just ask questions and write down answers. Instead, engage in a dialogue with the person. You can take brief notes as necessary while this dialogue goes on, and then enter information in the form later. If some answers are not available, just leave them black until the person is ready to give that information.
   - When you do write or enter information on the form, make sure the person can see what you are writing. Constantly check for approval of or agreement with what you are writing, and correct it immediately if he or she wants it written another way. Do not finish the form by yourself, even if you are using the individual's information. This is something the two of you do together, in collaboration.

8. Word your questions in ways that will invite the person to give a lot of information and respond to his or her answers in ways that invites more information and makes it clear that you are not judging his or her answers.
   - Make sure questions are open-ended, leading to more detail or conversation, rather than a simple "yes" or "no." If you are in doubt, try asking yourself the question before you ask the individual, to make sure that it requires more than a one-word answer.
   - Use active listening (e.g., "Okay, let me see if I understand… Is this what you meant...?") and expressions of empathy (e.g., "That sounds scary!") to connect with people, to gain a better understanding of their emotions and to let them know that they are heard and understood.
   - Probe answers for more detail, so you can get a better understanding of the individual's strengths, needs, priorities, and decision-making processes. For example, if the person describes a love of music, you might ask what kind of music, what artists or songs in particular, when does the person like to listen, how does it make him or her feel, does the person play music or think about learning to play, etc.
   - Avoid using the word "why" when you are probing for more information. That can make it seem as if you are implying that they need to defend or justify what they have said. So, for example, instead of asking, "Why do you want to have a baby someday?" you might ask, "What is it about having a baby someday that sounds most appealing to you?"
   - Follow the natural flow of the conversation, going where the individual receiving services wants to go, even if it seems off the subject. People often have an easier time remembering things if they follow the "road maps" that their own memories provide.

Think of the participant as a storyteller and you as a grateful, respectful, and interested audience for the story. If the answer to one question leads to a longer story, listen for information that might be useful to the assessment process, and make a mental or written note of that information. Many of the questions listed on the form may be answered through this natural, free-flowing narrative-and-listening process, eliminating the need to ask those questions.

If the person tells you about a negative, painful, or traumatic experience:

- Show or say (sincerely) that you witness and respect the pain and trouble that he or she has experienced.
- When the individual has given you his or her basic statement about what happened, gradually start to ask questions about the strengths and resources that helped the individual get through those experiences, for example:
  - When did you know that you had gotten through that experience?
  - What were some of the strengths that got you through that experience?
  - At that point in your life, who helped you feel loved and understood?
- If this disclosure seems to leave the individual feeling emotionally unstable, bring him or her back to the present by conducting a Grounding Exercise. Bring in more help if the person continues to be unstable or is showing signs of post-trauma reactions. Continue to monitor his or her reactions, and make sure that he or she does not leave the session in an unstable state without the proper clinical help and support.
- Use your own coping skills, human connections, and sources of support to address whatever discomfort this information might raise in you.

Here are things you should not do in response to someone's telling you about painful or traumatic experiences:

- Do not quickly try to change the subject. That would give the message that what he or she is saying is shameful or horrible, or that you cannot handle it.
- Although it is important to be understanding and empathic, do not try to console him or her or make his or her emotions go away.
- Do not try to make it a "teachable moment" by reframing it as a positive experience or a source of valuable lessons or survival skills, or by saying that "Everything happens for a reason." This would disrespect the person's experience and the grieving process.
- Do not try to reframe illegal, destructive, or self-destructive actions as being somehow worthwhile because of a particular outcome. This will not help the person learn more positive choices.

If this kind of conversational interview process is new to you, you might want to ask your friends or co-workers to play the role of the individual (making up any kind of history they want) and let you complete an assessment interview with them. Do it enough times, with enough people, to build your skills and feel comfortable conducting this conversational assessment interview process.

Deep Dive: Philadelphia Guidelines for Facilitating Peer-Run Groups and Meetings

PURPOSE

Early in Philadelphia's recovery transformation process, many individuals in recovery made a commitment to use their lived experience to motivate and support others in their recovery journey by becoming certified peer specialist. These efforts go far beyond developing new recovery support programs or adding peer support services to the existing traditional service structures. Recovery transformation is about creating and reinventing a more holistic system of care. "The integration of peer staff has many benefits, one being that it moves a system beyond short-term stabilization to helping individuals achieve sustained recovery, find meaningful roles in their communities, and fulfill their highest potential" (William White Peer Monograph). At this time Philadelphia identified a need to provide current and future peer staff with Group Facilitation Skills Training. This training historically focused on some basic facilitation skills and how to start up a self-help support group.

This document is intended to serve as a high level road map for designing and implementing peer-run groups and meetings. Included in this document is an overview on the types of groups, benefits of groups, managing logistics, facilitation tips, and conducting an evaluation.

TYPES OF PEER-RUN GROUPS AND MEETINGS

- Self-Support / Self-Help Groups
- Educational Groups
- Life Skills Groups
- Peer-Run Meetings: Peer Advisory Council (PAC), Co-Supervision
- Community Based Meetings
- Outreach Presentation
- Storytelling Training
- Focus Groups
- Advocacy Groups

Groups can occur:

- **Pre-Treatment:** For individuals not yet ready or able to engage in treatment. Will often include motivational interviewing techniques along with education.
- **Initial Engagement:** For individuals just beginning treatment; can be used as part of a warm welcoming and orientation process.
- **During Treatment:** In addition to therapeutic groups provided by clinical staff, peer-run groups can provide participants with a variety of support, education, and life skills topics.
- **Post-Treatment:** These groups can serve as a mechanism for continuing support and early re-intervention. Recovery Check-Ins; Alumni Groups.

IDENTIFYING AN APPROPRIATE LOCATION

It might be best to hold numerous peer-run groups in multiple parts of the community and at a couple different times of day so that people have easy access and options. The space for the peer-run group is important. Ideally, groups should be conducted in a location that is easily accessible by the people in recovery and in their natural environment or onsite at the treatment

program. It would be nice for the peer-run group room to have a large table or enough space so that individuals could be seated in a circle of chairs. The groups should also be held in a private room, rather than in an open common area so that there is a sense of privacy and people will feel more comfortable participating and sharing their thoughts and feelings. You should always identify handicap accessible locations.

FACILITATING THE PEER-RUN GROUP

Using Effective Facilitation Skills

The peer-run groups will be as successful as the facilitators are in their role. It is strongly encouraged that peer support staff who are interested in facilitating groups receive training in group facilitation skills, Mental Health First Aid, and motivational interviewing. Here are some characteristics of effective facilitators:

- Interacts informally with participants before and after the focus group
- Emphasizes the value and unique perspective of the participants' voices
- Goes with the flow of the conversation and avoids expectations, yet is able to move the conversation back on-track
- Makes eye contact with the participants when they are talking
- Demonstrates active listening techniques
- Uses nonverbal communication techniques to encourage participants and demonstrate interest in their perspectives
- Encourages the participants to interact with each other by using their names and asking effective follow-up questions
- Demonstrates empathy and positive regard for participants
- Has in depth knowledge of this area
- Restrains from expressing personal views

Benefits of Groups

A well-facilitated group offers the following six key benefits for participants:

- **Mutual support from others** – ability to receive support from peers
- **Universality** – an opportunity for participants to experience that their challenges are not just their own but often are experienced by others in the group
- **Sense of belonging** – fosters sense of connection, being part of a group and understood by others
- **Reality testing** – allows for participants to see how their internal thoughts, feelings and perspectives line up with those of others
- **Instilling hope in others** –opportunities to share experiences of overcoming challenges to help others going through similar experiences
- **Altruism opportunities** – opportunities to engage in selfless acts by supporting other group members

Structuring a Peer-Run Group

Most groups typically last 1 to 2 hours. It is important to always be mindful of time. You want to begin and end on time as well as allow for a break if needed. In many instances, light refreshments or drinks may precede the group.

Meetings have three components:

1. **Launching**
2. **Facilitating**
3. **Closing**

Launching a Meeting

The goal of launching a group or meeting is to welcome the participants and to set expectations. All tasks in launching a group or meeting should be kept brief, as the focus should be spent on the main topic of the group. It will be important that in the very beginning of the time together, the facilitators clearly articulate the goal and purpose of the group. The facilitators should briefly introduce who they are as well as their knowledge or experience in the subject matter. The facilitators should also provide a brief snapshot of the format, timing, and what is expected from the participants. For instance, clarify if the group format will be lecture, interactive, group sharing, team building, planning, etc. The facilitator will welcome the group participants, introduce the group topic, and typically begin with an icebreaker. An icebreaker is a technique used to initially engage all participants in an activity. The icebreaker should only take a few minutes and should be fun and light hearted. An example of an icebreaker is to have everyone introduce himself or herself with an adjective describing themselves starting with the first letter of their first name (Happy Harry, Amazing Amy, Funny Frank, etc.). It is always helpful for the facilitators to model the icebreaker for the audience. To create a safe environment for sharing the facilitators should always engage the participants in a discussion regarding group norms, safety, and expectation.

One of the most important tasks of the facilitators will be the creation of safe, comfortable environments that promote open sharing. It is important for the facilitator to establish ground rules after the introduction and prior to the discussion. Here are some ground rules that the facilitator might use to make the participants more comfortable speaking openly and honestly:

- There are no right or wrong answers.
- Everything shared in the room will not be taken outside of it.
- Stories about personal experience are valued and important, but should be kept brief.
- Due to the minimal time available for the discussion, the facilitator may have to ask people to wrap up their comments. This is not intended to be disrespectful or to discourage sharing, rather it is intended to ensure that everyone has the time available to participate and that there is enough time available to move through all of the questions.
- Personally attacking or critiquing others' comments is not okay.

Special attention should be paid to communicating key messages related to confidentiality. Examples include:

- Any recommendations or needs shared may be submitted to the program management for consideration.
- The conversation that takes place during group should be kept confidential. Peers must agree that they will not leave the group and share for example "Sheri said….".
- Pending on the group, you may have a note taker. The notes that the note-taker is taking will not document who is making a statement, it will just document what was said. The facilitator should explain how these notes will be used to ensure that all of the valuable feedback and insight from participants is captured and that themes can be identified.

Most important, in an effort to create safety, facilitators should ask the participants what they need in order to feel comfortable participating. Are there other guidelines in addition to the ones identified above that they think should be used to ensure a safe and positive experience for everyone? Any comments should be documented on newsprint so that everyone can see them and the participants feel comfortable that their comments are taken seriously.

Tips for Launching a Meeting

- Always start on time.
- Have an agenda.
- Clearly state the meeting goals and objectives.
- Have refreshments, if possible.
- Ensure that there is a large sign or greeter outside so folks know how to get to the group room. Have a number for folks to call if they cannot find the meeting area.
- Use a flip chart to document the group norms so you can reference them, if needed (i.e., No cell texting or answering phones).

Facilitating a Group or Meeting

After the group has been welcomed and the expectations have been set, now it is time to move into facilitating a discussion. The goal of facilitating a group or meeting is to achieve the goals and objectives you (and the group) identified. The goals will vary depending on the type of group you will be facilitating. The facilitator should always have curriculum or plan in place that is well rehearsed and timed. It is best to facilitate meetings in teams of 2 to 3 people. The roles of the facilitators should be clear and understood. The facilitators should meet before the meeting to plan and after the meeting to debrief successes and lessons learned.

Tips for Facilitating a Meeting

- Follow an agenda and stay on task.
- Build in time for breaks.
- Use visual aids where appropriate.
- Ensure that directions are clear and provided to participants. If possible, provide directions in writing.
- Select the right activity
  - The goal of individual work is to do a self-assessment, process information and/or to do an internal brainstorm of identifying strengths, challenges, values, attitudes, goal setting, etc.
  - The goal of group work is promote team building, team brainstorming, cross sharing, learning from each other's experiences and promote group problem solving.
  - Scenarios provides a factitious situation where the individuals and groups can process what they just learned and identify what is aligned with the new material, what is not, as well as what they would do in this particular situation.
  - Role Plays help participants practice what they just learned, as well as build skills and confidence.
- Practice active listening (be authentic, compassionate)
- Ask open-ended questions to elicit more information while respecting members
- Use I statements when you need to challenge, provide feedback or suggestions
  - I heard…
  - I see…
  - I understand…
  - I feel…
  - I believe…
  - I hope…

Tips for Closing the Group or Meeting

- Always end on time. Ending on time is respectful of the participants' time and other commitments.
- Be sure to first take a few moments to summarize common themes and key messages discussed during the group or meeting.
- Thank individuals that participated and helped make the group or meeting possible (host organization/volunteers/participants).
- Always provide next steps, whether it be the date and time of the next meeting/group and/or other available supports or resources.
- Be sure to provide some closing remarks and allow for participants to do the same. This provides you the opportunity to end the meeting with humor, words of wisdom, a positive note.
- Provide the participants with a basic evaluation tool that asks them for feedback on the events, for example, what went well (enjoyed most), what was not as helpful/relevant and what they would like to see, do, or learn more about in future meetings/groups. The questions should be relevant to the type of group that occurred, but it is always good practice to receive feedback from the participants to assist you with refining your skills, approach, and materials. This should be a form that you provide to the group at the end of the session and collect before they leave.

BEING PREPARED: MATERIALS AND SUPPLIES

Most groups and meetings generally require materials. Depending on the type of group and the goal of the group the materials will vary. However, there are a few cross cutting essential supplies/materials to consider for all meetings:

- A sign in sheet with contact information
- Handouts: agenda, resources, fliers, activities, etc.
- Flip chart paper, makers, and easel
- Name tents or name tags
- Lap top and projector (for PowerPoint presentations)
- Extra pens and note cards for participants to share additional ideas or thoughts
- Laptop or pen and note pads for recorders
- Tables and chairs
- Snack, light refreshments and paper/plastic goods (napkins, cups, plates)

RESOURCES

When proposing and introducing a peer-run group, always consider what the associated costs might be. Many community partners will donate time, space, equipment, and materials to recovery support service providers. Always look into community partnership opportunities. Cost-related items to consider include the following:

- Staff time
- Materials & supplies
- Fliers and promotional materials
- Refreshments and snacks
- Venue fee or rent
- Tables, chairs, & audio/visual equipment

MARKETING AND PROMOTION

You just completed the DBHIDS Groups Facilitation Skills training and are excited to have your first meeting. You worked so hard to develop an agenda, PowerPoint presentation, group activities, even splurged on coffee and fresh fruit. However, the day of your meeting you are feeling disappointed and discouraged because no one showed up. Every facilitator and trainer has experienced this unfortunate situation and has felt these humbling feelings. A key lesson learned to prevent a low to no show event is through effective outreach, marketing, and promotion. Follow these four key steps to increase your attendance/participation:

Step 1: Identify your Target Audience

Who is this meeting/group/event intended for? What is the best or preferred method of communication with this group (Email, text, phone, face-to-face)? Where do these individuals live, hang out, or frequently visit (shelter, apt building, barber shop, outpatient program)?

Step 2: Market

This is your opportunity to promote your meeting. Once your target audience has been identified assertively reach out to them to invite them to the meeting. Create fliers that can be posted or distributed where they live, hang out or visit. Provide eye-catching details and info on the flier. Include meeting/group name, date, time, location, and contact person. Always include perks—refreshments, special guest speakers, door prizes, etc. Invite folks that you know via their preferred method of communication.

Step 3: Track Registration

It is always a good idea to track registration. Have folks sign up to attend with their contact info. If you have their contact info, you can then conduct pre-group contact with participants through reminder phone calls, emails, or texts. Have folks sign up a few weeks before the event - if they have too much notice they may forget, if they have too little notice they may not be available. If someone does not show, then you are able to do follow up calls to check in on them and potentially schedule them for another time.

Step 4: Solicit Feedback from the Target Audience

Conduct a focus group or a brief survey with your target audience to determine what they would like groups to focus on, as well as the preference around meeting time, day, and location.

Guidelines for Establishing Group Norms for a Peer Advisory Council

The members of the Council will set their own guidelines, expectations, and meeting norms. The role of staff is to present these topics to the members of the Council for discussion and decision making.

CHAIRS AND OTHER LEADERSHIP POSITION

- How will PAC members select/nominate the leadership positions?
- What positions will we need (co-chairs, secretary, etc.) and what are their roles and responsibilities? (Having two people in co-chair positions is advised).
- How long will individuals will serve in these roles?

MEETING LOGISTICS

- Time: What time of day does the group prefer to meet?
- Location: What is the most convenient location for members to meet?
- Frequency: How often should the PAC meet?
- Duration: How long should each meeting be?
- What resources (tables, chairs, pens, paper, phone, food, etc.) are needed to be productive?

MEETING ATTENDANCE

Consistent attendance is crucial to the development of our Advisory Council, as well as to the organization as a whole. To that end, PAC members will need to decide on norms and expectations for attendance.

- What happens if someone misses a meeting?
- If someone is having transportation problems, can they call in?
- Is there a cap on how many meetings a person can miss before they are removed from their position?
- Will a Council member reach out to someone who did not show?
- Will someone send meeting reminders out to folks?

MEMBERSHIP

- How long will the members serve on the Council? (3 months, 6 months 1 year, etc.)
- How will new members be identified, invited, and oriented?

MISSION STATEMENT

The organization should provide the PAC with a charge and big picture goals. However it will be important for the group to help define their own mission statement. To begin this discussion, ask:

- What do the members of the Council hope to achieve by joining this leadership group?
- What are their hopes for the future?
- What brought you here today?
- What should this group be called? Explain what the name means to you.

CULTURE

What group norms or rules do you want to put in place to ensure that this is a safe and comfortable place for everyone?

- There are no right or wrong ideas, everyone's ideas are valued and listened to.
- The group will vote to make decisions.
- Everyone will be treated with dignity and respect.
- Members won't get defensive or take it personally if others disagree with their ideas.
- We will look out for and support one another.

Sample Invitation to Become a Member of a PAC

[On letterhead]

Name
Address
Date

Dear _____:

The [name of your organization] is seeking your membership on our newly formed Peer Advisory Council (PAC). You have been recommended by [peers, clinical staff, etc.] as someone who would have a lot to contribute to our discussions and activities.

By joining our PAC, you will work with other council members to advise our Management Team on how we can continually improve services and supports to the individuals and families who come through our doors. Peer Advisory Council members also serve as recovery advocates and ambassadors throughout [city or community].

We invite you to meet others on the PAC and to learn more about the responsibilities and leadership opportunities the membership offers. Please join us on

Date:
Address/Room:
Time:
Contact: (name and cell number)

Refreshments will be served.

Please let us know if you will be able to attend the meeting by contacting [name email and phone number of the person managing the RSVPs].

We hope to see you there!

Sincerely,

[Name]
[Title]

Elements of a Memorandum of Agreement

Partnership Vision, Purpose, and Concept: The opening section identifies the partners (full name and address) and sets the tone and vision for the partnership. Clearly define the mutually agreed upon purpose and concepts for the partnership, why this work is important, and what values lead and inform the work. This part should be succinct, only a few sentences.

Partnership Goals and Desired Outcomes: This section will specify and summarize the mutually agreed upon goals and desired outcomes. Clearly define the target audience, numbers of people to be served, types of services that will be offered, etc.

Description of The Participating Organizations: Provide a high-level overview (1 paragraph) describing the organizations.

Methods of Partnership Roles and Responsibilities: To coordinate and use the resources of each partner to the fullest advantage in implementing the vision and achieving the goals, organizations will agree to specific roles and responsibilities. Section 4 should be the most detailed section of the MOA. Clearly state who is doing what to achieve the goals and desired outcomes. This section should also indicate how success will be determined and measured and who will measure it.

Legal Disclaimers: This section explicitly acknowledges that all partners understand and agree that the MOA is not a contract, is not intended to replace a contract, and does not possess the same particular legal status as a contract. This section should also states that partners also do not intend for the MOA to be enforceable by any judicial, arbitral, or administrative body.

Periodic Review: Representatives from partners will jointly evaluate progress in the implementation of the MOA and revise and develop new plans or goals as appropriate. An example:

> In Year 1, partners will jointly evaluate progress on a quarterly basis (identify dates).
>
> In Years 2 and 3, partners will jointly evaluate progress on twice yearly (identify dates).

Term of Memorandum of Agreement: This section indicates the MOA's start date and terminate on end date. Six months prior to termination, the parties will meet to review the progress and success of the MOA and to determine whether it will be extended the partnership. This section also contains termination clauses, such as that it understood by partners that at anytime this MOA may be terminated with written notification from any party to the others.

Miscellaneous: This MOA does not provide either party with the authority to bind the other.

Authorized Signature: Each partner will need to have an authorized, decision maker sign and date the MOA.

Menu of Continuing Support Checklist

SUPPORT	YES	NO
Peer-led groups		
Telephone-based check-ins		
Participation in the Peer Advisory Council		
Texts and/or emails from recovery coach		
Periodic check-ins with counselor		
Meeting with peer staff in the community		
Meeting with peer staff at this organization		
Support and/or outreach from volunteers		
Home visits		
12-step fellowships		
Other mutual aid support groups		
Faith-based supports		
Participation in community service activities		
Family support		
Recovery celebration events		
Recreational activities with others in recovery		
Ongoing assistance with basic needs, e.g., transportation, employment, education, child care		
Volunteering to engage other people in recovery		
Developing friendships with other people in recovery		
Recovery advocacy activities		

Can you think of any other supports that may be helpful to you in sustaining your recovery? If so, please list them below.

1. Which of the supports that you identified are not in place in your life right now?
2. Which would you like to work on developing together?

Tips for Assertive Outreach or Re-Engagement

You are a peer support staff member and just started working with a group of individuals at a local treatment organization. When you received services a year ago, peer staff were not as prevalent, and you saw people who did not receive the individualized type of help that they desperately needed and ultimately most became disengaged. You really believe peer support services are needed and you are excited about your role and your opportunities to help others and give back. A fundamental role of peer support is to help keep people connected to recovery support services. In this role you will come across people who are 100 percent engaged, motivated, and who maintain excellent contact with you.

However, you may also come across individuals who

- do not show up for appointments.
- state that they just needed treatment and no longer want help with recovery beyond treatment.
- have a few months of recovery and recently got jobs so believe that they do not have time for recovery supports.
- have slipped and are too ashamed to come back to the program or ask for help.
- leave treatment early (against the advice of medical or facility staff) to take care of children or legal matters.

Historically, individuals who didn't not adhere completely to treatment plans were labeled not serious, not compliant, or not motivated about their recovery. And the individual in the helping role would passively wait for the individual to call or return for help when they were "ready."

With a recovery-oriented approach, this thinking has shifted. The responsibility for re-engagement is now on the helper. When people being served begin to disengage, it is the peer staff's responsibility to encourage continued engagement in recovery support services and to inspire hope for their long-term recovery journey.

Telephonic outreach is the first step in assertive outreach and re-engagement. These practices can help re-engage someone who has begun to show signs of disengagement.

Celebrate. Always acknowledge progress and celebrate success.

Normalize setbacks. Acknowledge that having a setback is not a failure; it is an opportunity to identify lessons. Inform them that most people on the road to recovery experience a setback, and it is not the setbacks that define us, but how we move forward after adversity. If the individual has had a setback, find and celebrate the strengths in that experience. For instance, perhaps they sought help quickly after the setback; had a setback that was shorter and less intense than the last; or were able to identify what led to the setback, and so on.

Maintain relevance. When individuals stop following through with contacts or want to end services, explain that peer staff offer more than just moral support to initiate and achieve wellness or recovery. Ask about future goals and aspirations. Explain how you could continue to assist in these goals. When individuals miss an appointment, ask probing questions to identify what got in the way. Was it childcare? Illness? Transportation? Whatever it might be, offer help and problem solve to remove the barriers.

Sell it. Explain that recovery is a journey and that staying connected to supports over a long period of time greatly assists achieving long-term recovery. (Avoid sharing the horror story of folks who had setbacks when they were no longer interested in service. But do share about people in general who have been working intentionally over time on their recovery and how the peer support relationship has shifted to stay relevant to their needs.)

Be flexible and plan ahead. Acknowledge that, as their lives are getting back on track, you understand that they have competing demands such as school, family, work, and housing. Regardless of a person's circumstances, it is helpful to have a peer support provider connected to multiple resources and community partners who can support and advocate for the person, as needed. Explain that you have a very flexible schedule and can speak or meet with them at a time convenient for them.

Script for Explaining Telephonic Recovery

Hello, my name is _____ and I am a _____ with _____.

I'm calling to see if you'd like to get recovery support by telephone. Do you have a few moments to talk?

[If Yes]:

The purpose of Telephonic Recovery is to give you another resource for support during your recovery journey and to help connect you with other resources. Our support is simply telephone calls from a peer. On the calls, we will discuss the positive things you've been doing to further your recovery, your ongoing recovery goals, and any recent struggles that you have been facing. We will identify any additional supports, resources, or referrals you may need.

These calls do not replace the long-term relationships and partnerships you have with a peer specialist, coach, case manager, sponsors, or anyone else.

Does that sound like something you may be interested in, or would you like more details?

[If Yes]:

If you would like to receive this service, we will be calling you once a week for the first couple of months. The calls usually last 15 to 30 minutes. You are also welcome to call me at any point to check in or if you have any urgent matters. We'll have calls together less often as your recovery progresses. And we can always increase the number of calls again, if needed.

We will agree on specific dates and times that work best for you. We will always confirm our next call at the end of each call.

Do you have any questions?

Would you like to participate in this service?

Source: Based on "Sample Scripts to Introduce Telephone Recovery," by the Telephonic Recovery Initiative Project (no date), Philadelphia Department of Behavioral Health and Intellectual disAbility Services.

Telephonic Check-In Tool

Recovery check-ins provide an ongoing mechanism to support and monitor progress toward sustained recovery, while providing a structure to balance focus on the immediate needs of here and now, with movement towards long term recovery goals.

Name:
Location or phone number:
Date of contact:
Time of contact:
Name of peer staff:
Has your contact info or emergency contact info changed? Yes / No If yes, who is new contact?
1. What's going well with you today?
2. How are you feeling today? Why do you think that is?
3. On a scale of 1–10. With 10 being not well and 1 being extremely well. How well have you been able to maintain your recovery? (circle) 1 2 3 4 5 6 7 8 9 10 *Answer 5–10 presents potential risk for further clinical support.)*
4. Managing your recovery can be challenging. What was your experience with managing your recovery since the last time we met? *(Probe: When did you use last and how much did you use? Are you taking your medication as prescribed?)*
5. What is your stress level on a scale of 1 to 10 where 1 is not much stress and 10 is terrible stress? (circle) 1 2 3 4 5 6 7 8 9 10 5a. Answer 1– 4. It sounds like your finding some ways to keep your stress levels low. What are you finding that is working for you? 5b. Answer 5–10. What's contributing to your stress? (Presents risks, consider further clinical support.)
6. Do you have a safe place to stay tonight that is supportive of your recovery goals?
7. Since our last check-in, what progress have you made toward your recovery goals? 7a. What is getting in the way? 7b. What support do you need from me and or others right now?
8. What are one or two things that you can do to continue your progress before we touch base next time?
9. Staff notes (additional information or next steps)

Module 4 Tools

Practice 1. Provide Three Types of Supervision

- Organizational Guidelines for the Delivery of Supervision to Peer Staff
- Supervision Agreement Template

Practice 2. Provide the Right Supervisory Structure

- Group Supervision Tips
- Developing a Co-Supervision Working Agreement
- Tips for Giving and Receiving Reflective Feedback During Co-Supervision

Practice 3. Ensure that Supervision Is Consistent, Accessible, and Helpful

- Individuals Served Progress Review Tool
- Shadowing Tool Facilitator's Guide
  - Shadowing Tool
- Peer Mentor Checklist Facilitator's Guide
  - Peer Mentor Checklist
- Supervision Session Documentation Template

Practice 5. Collaboratively Assess Strengths and Areas for Growth

- Interim House Inc. Staff Feedback Form
- Aspects of Diversity Self-Assessment Facilitator's Guide
  - Aspects of Diversity Self-Assessment Form
- New Employee Self-Assessment Facilitator's Guide
  - New Employee Self-Assessment Tool
- Supervisor's New Employee Orientation Checklist

Practice 6. Familiarize Supervisors With Common Concerns of Peer Staff

- Agency Assessment of Common Peer Staff Concerns Facilitator's Guide
  - Agency Assessment of Common Peer Staff Concerns Scale

Practice 7. Help Peer Staff Develop Time Management and Documentation Skills

- Supervisor Tips for Documentation
- Documentation Self-Assessment Tool Facilitator's Guide
  - Documentation Self-Assessment Tool

Practice 11. Provide the Right Supervisory Structure

- Recovery Wellness Cafés Facilitator's Guide
  - Recovery Wellness Cafés
- Self-Care Assessment
- Professional Quality of Life Scale
  - ProQOL Scoring

Organizational Guidelines for the Delivery of Supervision to Peer Staff

The following guidelines may serve as a starting point for your organization in crafting guidelines that fit your context.

Frequency: Individual supervision of peer support staff should be provided weekly.

Duration: Individual supervision sessions should last for one hour; group supervision sessions should last 90 minutes.

Location: Barring emergencies, supervisors should be prepared to offer their undivided time to their supervisees. To facilitate this, supervision should take place in a location that is free from distractions.

Responsibilities: Both supervisors and the supervisees are responsible for ensuring that the supervision process is effective. Their roles and responsibilities are documented in the Supervision Agreement.

Documentation: Supervisors and supervisees should collaboratively document the focus of each supervision session and the next steps that each person commits to taking prior to the next session. Supervisors should retain a copy for their records and offer supervisees a copy. Any documentation that addresses confidential information should be kept in a confidential location that only the supervisor, appropriate Human Resource staff, or other senior leadership are able to access.

Together, supervisors and supervisees should also document training/supervision goals. The documentation process should be used as a means of ensuring that supervision is focused on the immediate needs of the individuals served, as well as on the long-term training and professional development goals of the supervisee.

Boundaries: Supervisors and supervisees should discuss and agree upon a set of boundaries that guide their supervision relationship. Examples of the kinds of topics to be covered include how to access the supervisor in the event of an after hour emergency, what kinds of situations constitute an emergency, differentiating supportive supervision and counseling, etc.

Agreement: The supervision agreement document should be reviewed, agreed upon, and signed by both supervisors and supervises during the first supervision session. The agreement should be reviewed minimally twice annually to determine if any changes to the focus or process of supervision are needed.

Addressing Challenges and Providing Feedback: It is expected that developing an effective supervisory experience will take time and effort on the part of both supervisors and supervisees. During the context of this work, both parties need to be open to both giving and receiving feedback with the goals of identifying what is currently working or not working as well. Supervisors should regularly ask their supervisees what would they like more of, what would they like less of, and is the format meeting their needs. This open dialogue about the process creates a culture of transparency and flexibility and empowers peer staff to play a role in ensuring that they get what they need from the supervision experience. Similarly, supervisors should provide peer staff with regular feedback regarding their professional performance and development.

Adapted from the Office of the Nursing and Midwifery Service Director, 2015, Clinical Supervision Framework for Nurses Working in Mental Health Services.

Supervision Agreement Template

This is an agreement between _____ **(supervisee)**

and _____ **(supervisor).**

Type of Supervision: ☐ **Individual** ☐ **Group** ☐ **Both**

Frequency of Individual Supervision: _____

Frequency of Group Supervision: _____

1. Goals of Our Supervision

a. To ensure that quality services are provided to the people being served

b. To promote the supervisee's professional development and competence

c. Others, as identified by the supervisor and supervisee:

_____

2. Rights and Responsibilities

a. Supervisor Responsibilities

i. To make sure that supervision sessions take place as agreed

ii. To collaboratively assess the supervisee's strengths and areas for continued professional development

iii. To continually ask about training/coaching needs and ensure that the peer staff is connected to relevant resources and opportunities and that relevant information is shared in the supervision sessions

iv. To use a supervisory form to document the focus of and next steps for each supervision session

v. To ensure that the peer staff is clear about his/her role and responsibilities

vi. To ensure that other staff are clear about the role and responsibilities of the peer staff and when needed provide additional clarity

vii. To review the supervisee's approach with individuals to ensure that it is consistent with a recovery-orientation and provide support, guidance, and redirection if needed

viii. To ensure that each person working with the peer staff person is receiving the correct dose of support based on the intensity of their needs

ix. To ensure that the specific agenda items for each session are identified collaboratively

x. To support the staff person in identifying their professional development goals

xi. To ensure that peer staff have access to all of the resources that they need to be effective in their roles

xii. To provide needed support related to documentation and any other administrative tasks beyond direct service delivery

continued

Supervision Agreement Template *continued*

b. Supervisor Rights in supervision:
   i. To raise and address any concerns regarding performance
   ii. To observe the supervisee's direct practice and provide support and direction, if needed

c. Supervisee Responsibilities in Supervision:
   i. To come to supervision sessions prepared to discuss their work with particular individuals and ready to discuss any challenges that they are experiencing
   ii. To consult their supervisor when they are confronted with a situation that is beyond the scope of their practice as a peer provider
   iii. To be open to their supervisor's feedback and be willing to adopt alternate approaches if asked
   iv. To share if they are uncomfortable doing something that is being asked of them
   v. To track action items that arise in the course of supervision and be prepared to provide a status update during the next supervision session
   vi. To inform their supervisor if any aspects of their workload becoming too demanding
   vii. Maintain a commitment to ongoing professional development through identifying skill gaps and training needs

d. Supervisee Rights in Supervision
   i. To receive consistent supervision at the agreed upon time in a private location
   ii. To participate in setting the agenda for each session
   iii. To receive constructive feedback regarding areas for improvement orally and have an opportunity to correct before it is documented into any formal written performance reviews.
   iv. To have access to supervisor or _____ (name of alternate leadership) in the event of an emergency.

This agreement is subject to revision at any time, upon the request of either the supervisor or the supervisee.

To the best of our ability, we agree to uphold the guidelines specified in this agreement and to work collaboratively to develop a supportive and effective supervisory process.

_____

Supervisor

_____

Supervisee

This agreement is in effect from: Date: _____

Sources: Adapted from *Supervision Contract – Suggested Template by the National Association of Social Workers Ohio Chapter*; *Supervision Template*, C. Falender; *Guideline for Clinical Supervision Agreement by The Office of the Nursing and Midwifery Service Director, 2015*, Clinical Supervision Framework for Nurses Working in Mental Health Services.

Group Supervision Tips

The group format is used to disseminate information, maintain cohesiveness and a shared vision of the program, share experiences and knowledge, and role-play situations and responses. Ideally, peer support staff will participate in group supervision meetings as soon as they are hired so that they become accustomed to the format and understand that supervision is an essential component of the program. Below are some tips for conducting effective individual and group supervision sessions.

- Provide an hour and a half of group supervision on a weekly basis and at a regularly scheduled meeting time.
- Use a standard format for each session. For instance, briefly review all individuals being served (no more than 15 minutes to review all individuals served; withhold discussion on challenging situations until later).
- Always have an agenda and stick to time frames.
- Identify agenda priorities and understand that not all elements need to be covered at every meeting.
- Encourage participation and creativity.
- Respect opinions and ideas.
- Use humor and have fun.
- Encourage punctuality and reward promptness.
- Encourage problem solving, but don't immediately fix problems for staff.
- Keep staff on track and avoid extended discussions into other topics.
- Always explore the connection between peer support activities with the recovery plans that people initially developed for themselves.
- Limit discussions on any one person to a maximum of 15 minutes and keep staff members focused on the primary and relevant issue of the person.

Avoid topics, issues, or discussions that are not related to improving skills. Topics and issues that should be avoided from group supervision meeting include:

- Personnel and HR issues (benefits, time off, salary)
- Excessive complaining about particular people being served, other staff members, units or other agencies
- Discussions about peer support supplies; e.g., pens, post-its, etc.
- Matters related to personal recovery outside of the workplace

Source: Adapted from *Manual for Recovery Coaching and Personal Recovery Plan Development* by D. Loveland and M. Boyle, 2005, Illinois Department of Human Services, Division of Alcoholism and Substance Abuse, p. 25.

Developing a Co-Supervision Working Agreement

When developing an initial working agreement for co-supervision session, it may be beneficial to discuss working arrangements, ground rules, and individual responsibilities. It is advisable to keep the initial structure and framework flexible enough to be changed over time, as needed.

WORKING ARRANGEMENTS

Discussions about working arrangements may include the following:

Where and how often will the group meet? Group meetings should optimally be conducted weekly or bi-weekly. This provides enough regularity to develop a strong working relationship among group members.

How long will sessions last? Generally, 45 to 90 minutes is recommended for a co-supervision session. This allows for enough time to explore the topics and concerns that come up during a session and to reflect and plan for next steps.

How will the time be structured? It may be helpful to designate a specific amount of time at the beginning or end of the session for planning future sessions or checking in with group members. The group may also decide to create a fairly unstructured session, although this may be difficult for some members.

What will be discussed during the sessions? Agendas can vary based on the needs of the group, but a standing format can often work well in structuring the sessions, with room for change as needed.

GROUND RULES

Ground rules help the group members feel safe and comfortable, and they help establish shared expectations for the format and overall content of the group. Ground rules may resemble the following.

Group co-supervisees will

1. promote processes that will help individuals and the group obtain its goals;
2. introduce activities that promote goal attainment;
3. ensure that the group's culture, norms, structures, and relationships in the environment are conducive to the attainment of the group's goals; and,
4. facilitate group process and take action about the status of the circumstances of individuals and the group.

INDIVIDUAL RESPONSIBILITIES

Co-supervision participants are expected to attend meetings with an intention to learn, practice, and reflect. Therefore, they should bring stories and examples of how they are learning and practicing skills. For some, this may include taking notes and preparing an outline of what to present during supervision.

Tips for Giving and Receiving Reflective Feedback During Co-Supervision

Giving and receiving reflective feedback is an important part of a successful co-supervision relationship. Learning how to give and receive reflective feedback will enable continuous learning and growth. Below are points from Shery Mead (2008) that are particularly useful for co-supervision groups conducted in community-based settings.

GIVING FEEDBACK

Ensure connection and group cohesion. A co-supervisory group should ensure a safe learning environment. It may be useful to check in with group members to learn whether individuals feel comfortable in the group. Questions to consider include: Does it feel safe enough within the group? Are there factors that will distract group members from hearing one another? Refrain from offering feedback until a level of rapport has been established.

Focus on the positive. It is always useful when giving feedback to begin with the positive. Before giving feedback, ask your colleague to tell the group what worked well, and then focus on what could be improved. Then provide your own suggestions for what worked well and what could be improved. This opens up a broader discussion with the group and includes those things that are going well in the work. It also encourages reflection on behalf of colleagues.

Ask permission. Before giving feedback, be certain to ask whether the person is in a place to receive it. Based on the person's learning style, worldview, or other factors, it may just not be the right time to give people feedback. This may be especially true if a strong connection has not been established within the group. Timing is critical in allowing a person to benefit from the feedback being shared.

Strive for mutuality. Remember that co-supervision is about people learning from one another, regardless of the level of experience. By sharing stories and examples, all involved will be able to share in the learning experience.

Be aware of power. Are there power issues that may get in the way of providing critical feedback? It is important that these be addressed at the onset and throughout the group process so they do not interfere in the relationship among group members. Reminding participants that co-supervision is a non-hierarchical approach can be helpful.

Consider worldviews. Remember that we are all influenced by our worldviews. Discussing in the group how one's worldview may or may not have influenced an interaction is helpful in facilitating understanding, learning, and mutuality.

Plan next steps. Allow time for the individual to discuss ideas and plans for integrating into future practice the feedback and reflection on the situation discussed.

continued

Tips for Giving and Receiving Reflective Feedback During Co-Supervision

continued

RECEIVING FEEDBACK

The following are tips on how to receive, accept, and reflect on feedback.

Be aware of your defenses. Hearing feedback can be challenging. It is important to remember that co-supervision is a mutual relationship and that colleagues are there to learn from one another. Self-awareness is key to understanding what is not allowing one to make use of feedback being shared. Noting defenses such as rationalizing or denial can be a first step in understanding and moving beyond those first reactions.

Try to focus on your reactions to the feedback. What is the immediate response when someone gives unexpected feedback? What are the physical, emotional, and cognitive responses? It is normal to feel defensive or vulnerable; the key is being able to not react based on these feelings. As Mead states: "Breathe, listen from a 'position of not knowing,' and allow your defenses to take a back seat for a few minutes."

Remember there may be a grain of truth in all reflective feedback. A person may have thought that he or she did a great job, but received feedback that indicated something different. It is important to remember that both views are "truth." Use the feedback to inform reflection and motivate change.

Ask: "In light of this feedback, is there something for me to move toward?" Don't be discouraged by negative or critical feedback. Ask if is there something to take from this discussion that will improve service.

Source: Adapted from *Intentional Peer Support Co-Reflection Guide* by S. Mead, 2014, Burlington, VT: Intentional Peer Support, 2014. Used with permission.

Individuals Served Progress Review Tool

INTRODUCTION

Using supervision sessions to reviewing the progress of individuals being served can be a concrete strategy for routinely exploring peer staff successes, challenges, and resource needs, as well as a way to stay abreast of the overall progress of persons being served. This review can be conducted in either individual or group supervision session.

PURPOSE

To serve as a guide for conveying information about specific individuals being served to peer staff supervisors and for guiding a dialogue about how to best serve these individuals.

MATERIALS

Review questions; individual files

TIME

1–2 hours

DIRECTIONS

Supervisor will notify peer staff prior to supervision session that a review of progress made by some of the individuals being served will be a part of the session. The supervisor will also provide peer staff with a copy of the Review Questions so peer staff can prepare for the review. Peer staff will bring files to the supervision session for reference.

WRAP UP

At the close of the session, the supervisor will highlight the strengths and successes identified in the review. For any areas identified as barriers or challenges, the supervisor will coach peer staff around accessing resources, strategies, trainings, or tools that can assist in overcoming identified barriers and challenges. The supervisor and peer staff will collaboratively identify action steps and timelines for completing action steps as related to overcoming barriers and challenges. The supervisor will document strengths and successes as well as the barriers and challenges in order to follow up with peer staff in next session.

REVIEW QUESTIONS

- What is the individual's most pressing needs?
- What does the individual identify as the most immediate priority?
- What are some present or past obstacles to the individual's recovery?
- How are you helping the individual identify skills and strengths to address those obstacles?
- What is the extent and scope of the individual's recovery capital?
- How are you meeting the individual's needs and desires?
- What successes has the individual experienced?
- What community resources seem most relevant right now, or has the individual expressed a desire to get connected with particular resources?
- How frequent has your contact been? Is it primarily initiated by you or by the individual?
- What type of contact are you having (in-person, phone, text, group, individual coaching)? Does the level of support you are providing seem to be sufficient based on the challenges that this individual is currently experiencing?
- What feelings typically come up for you when working with this individual? Do you find it enjoyable, challenging, and frustrating? If difficult emotions surface, how are you addressing them?
- Are there any areas of diversity that have challenged you or that you could use more education around?
- Are there any other areas that additional training would help you in your work with this individual?

Shadowing Tool Facilitator's Guide

PURPOSE

For peer staff and supervisors to record and reflect upon their shadowing experiences

MATERIALS

Shadowing tools

TIME

Varies depending on shadowing experience (i.e., tasks, duration)

COSTS

Reproducing Shadowing Tools

DIRECTIONS

For supervisors
Use this tool to document observations around the peer staff provider's performance, interactions, and relationships with the people served. The tool can serve as guide for assessing how effectively the person delivers peer support services.

For peer staff
Use this tool to document observations of administrator, supervisor, or other peer support staff while shadowing daily activities. This tool can serve as a guide for assessing qualities, characteristics, approaches, strategies, and lessons learned from other staff that can aid in the delivery of peer support services.

TIPS

When a peer support provider is being shadowed by a supervisor, the supervisor should share and discuss the Shadowing Tool for Supervisors with the peer support person before and after the shadowing experience. An ideal approach would be to ask the peer support person to assess themselves using the same tool, and then meet to discuss the experience using the tool as a guide.

WRAP-UP

The shadowing experience should be followed by a conversation among the staff members involved in the shadowing process. The staff member who acted as the "shadower" should use this conversation as an opportunity to share observations, ask questions, seek clarification, and process the overall shadowing experience. The staff member who was shadowed should use this conversation as an opportunity to receive feedback on what was observed and any strengths as well as opportunities for growth and development. This conversation can also be a time to identify resources, supports, and strategies to address opportunities for growth and development.

Shadowing Tool for Peer Support Staff		
Organization:	Unit:	Date:
Observer:	Title:	Time:
Observee:	Title:	
Activity:	Location:	

Your Shadowing Experience

1. What did the individual you shadowed do well?
2. Were there any aspects of your shadowing experience that stood out as opportunities for improvement?
3. Is there anything that you would do differently?
4. What did you learn?
5. Did you identify any of your current strategies/approaches that you would like to modify or change? Have you identified new strategies that you would like to implement?
6. What items or next steps would you like to discuss with your supervisor?

Shadowing Tool for Supervisors		
Organization:	Unit:	Date:
Observer:	Title:	Time:
Observee:	Title:	
Activity:	Location:	

Your Shadowing Experience

1. What did the peer who you shadowed do well?
2. Were there any aspects of your shadowing experience that stood out as opportunities for improvement?
3. Is there anything that you would encourage the peer support staff member to do differently?
4. What did you learn about your peer support staff member's strengths and skill sets?
5. Did you identify strategies to modify? Are there new strategies that you would like the peer support staff member to implement?
6. What are items or next steps that you would like to discuss with the peer support staff member?
7. Identify training recommendations, if any.

Peer Mentor Checklist Facilitator's Guide

PURPOSE

To provide new peer staff resources and support while orienting them to their new role within the agency

MATERIALS

Peer Mentor Checklist; copies of forms peer staff will be learning how to complete

TIME

Varies

COST

Duplication of Peer Mentor Checklist

INTRODUCTION

Peer mentorship offers new peer staff an opportunity to receive guidance and support from a colleague who has lived experience in the role of peer staff within the agency. The peer mentorship relationship is beneficial to both the new peer staff and the mentor; the mentor is developing leadership skills while the new peer staff acquires valuable knowledge and support.

DIRECTIONS

The supervisor will identify a peer mentor who has the time and knowledge to adequately support new peer staff. Review the Peer Mentor Checklist with the peer mentor prior to starting the mentorship. The supervisor will work with the peer mentor to establish a schedule and timeline for completing the tasks. The peer mentor and the new peer staff should report regularly on progress toward addressing the areas covered.

TIP

Select a peer mentor who is established in their peer staff role within the agency and can provide accurate information to the new peer staff.

WRAP-UP

Upon completion of all tasks, the supervisor, peer mentor, and new peer staff should meet to discuss how the process went overall, what the new peer staff learned and any questions and concerns that may have come up.

PEER MENTOR CHECKLIST

PERSONAL INTRODUCTION

- Share a little about yourself and how you came to be in the role.
- Share some lessons learned, strategies for how you sustain your own wellness while doing this work, successes stories and examples of impact peer staff can have.
- Ask new peer staff what led them to enter into the role and what they hope to learn from you as their mentor.

Date:

Notes:

INTRODUCTION TO INDIVIDUALS SERVED

- Share information and notes about the people that the new peer staff will be working with.
- Introduce those individuals to new staff and help facilitate conversations.
- Help the people receiving services grow comfortable with new peer staff.
- Discuss successes and challenges with new peer staff regarding early interactions with individuals served.

Date:

Notes:

INTRODUCTION TO STAFF

- Introduce new peer staff to all staff in the agency.
- Describe the role of other staff and how they are interconnected.

Date:

Notes:

continued

PEER MENTOR CHECKLIST, *continued*

TOUR THE WORKSPACE
• Show new peer staff where to find supplies, break room, restrooms, etc.
Date:
Notes:

REVIEW DOCUMENTATION
• Walk new peer staff through entire documentation process (where to find forms, when to complete forms, where forms go upon completion, etc.). • Share your successes and lessons learned with documentation. • Discuss new peer staff's questions and concerns related to documentation.
Date:
Notes:

DISCUSS LONG-TERM GOALS
• Take time to learn more about new peer staff's professional goals. • Serve as a source of encouragement.
Date:
Notes:

continued

PEER MENTOR CHECKLIST, *continued*

SHARE INFORMATION ABOUT RESOURCES

- Show new peer staff where to find information to provide individuals served.
- Share knowledge of internal and community resources available for individuals served.

Date:

Notes:

SHARE INFORMATION ABOUT CROSS-PROVIDER PEER NETWORKING

- Describe the benefits of networking with other peer staff from other agencies.
- Share networking success stories.
- Have new peer staff accompany you to your next networking meeting.
- Introduce new peer staff to other peers you have relationships with.

Date:

Notes:

DISCUSS BENEFITS OF SUPERVISION

- Share the ways supervision has been instrumental to your work.
- Encourage new peer staff to utilize supervision; share examples of when to go to supervisor outside of scheduled supervision meetings.

Date:

Notes:

continued

PEER MENTOR CHECKLIST, *continued*

ONGOING SUPPORT OF PERSONS SERVED
• Review new peer staff's documentation with them and discuss the current needs, strengths, challenges, etc., of individuals served. • When people receiving peer support services are open to it, sit in on some sessions with new peer staff and then have a debriefing session to offer feedback on what went well and where you saw opportunities for improvement.
Date:
Notes:

CHECK-IN REGULARLY AND ONGOING
• Check-in with new peer staff to find out how they are acclimating to the role. • Serve as a resource and support when peer staff encounters difficulties. • Act as a cheerleader for new staff and celebrate successes with them.
Date:
Notes:

Supervision Session Documentation Template

Staff (name): _____

Supervisor (name): _____

Date: _____

Supervision Format: ☐ Individual ☐ Group

Focus of supervision and agenda items discussed

FOLLOW-UP

Follow-up Action Items/Practice Changes/ New Approaches to be Integrated	Person Responsible (Supervisee or Supervisor)

Source: Adapted from *Guideline for Clinical Supervision Agreement by The Office of the Nursing and Midwifery Service Director, 2015*, Clinical Supervision Framework for Nurses Working in Mental Health Services.

City of Philadelphia
DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

Interim House Inc. Staff Feedback Form

Peer Support Name: _____ **Date:** _____

Date of Observation(s): _____

Quality Indicators	Above Satisfactory	Satisfactory	Needs Improvement	Comments
Able to validate individual's feelings				
Sought supervision when needed				
Demonstrated flexibility when individual or community made suggestion				
Accepted feedback/constructive criticism from supervisory or other staff				
Related to other staff in an appropriate manner				
Did not become part of the crisis				
Maintained a respectful demeanor				
Offered choices to individuals served in program				
Provided an emotionally safe environment for individuals served in program				
Demonstrated a positive demeanor and created an atmosphere that promoted strength, recovery, and resiliency				
Demonstrated effective problem solving				

Peer Specialist's Signature: _____ **Date:** _____

Note: Your signature indicates these observations were shared with you; if you disagree, you many note it on the form.

Supervisor's Signature: _____ **Date:** _____

Aspects of Diversity Self-Assessment Facilitator's Guide

It is natural that we find some people to be easier to work with than others. This self-assessment helps you become more aware of people you feel most comfortable with as well as those that may be more challenging for you to connect to. This self-assessment can then facilitate a supervisory discussion about having greater insight about potential challenges. It is important to remember that although we are all conditioned to have some conscious and unconscious biases, peer staff ought to become increasingly aware of and be willing to work though all biases and challenges.

PURPOSE

For peer staff to become more aware of attributes and characteristics that they feel most comfortable with as well as those that may be more challenging.

MATERIALS

Aspects of Diversity Self-Assessment Form (next page)

TIME

2 hours (completion of self-assessment and discussion time)

COST

Duplication of Self-Assessment Form

DIRECTIONS

Supervisor will explain that peer staff will work with an array of individuals, some of whom they may find easier to work with than others. The supervisor will instruct peer staff to fill out the self-assessment to the best of their ability, noting any questions they have regarding any of the attributes or characteristics listed. Peer staff will complete the self-assessment by marking whether they have experienced difficulty or discomfort working with people with the identified attribute or characteristic (or anticipate having difficulty).

TIP

It is important for the supervisor to create a safe space for honesty and transparency with this activity. To do so, it can be helpful for the supervisor to self-disclose a particular attribute or characteristic that they themselves have had difficulty working with. This use of self-disclosure can help normalize the notion that all staff experience some attributes/characteristics as personally challenging to work with. The supervisor can also share their own strategies for how to effectively work with individuals who present a personally challenging attribute or characteristic.

WRAP-UP

The completed self-assessment will serve as a guide for supervisory discussion. This discussion should include the peer staff's experience with completing the tool, any questions they had regarding particular attributes or characteristics, any attributes or characteristics they identified as being somewhat or extremely challenging, and any attributes or characteristics the peer staff was unsure about. The discussion should also include collaborative strategizing around what to do if an individual presents with one of the difficult attributes or characteristics. Lastly, any education or training needs that arise should be addressed and noted for follow-up.

Aspects of Diversity Self-Assessment Form

GENDER IDENTITY AND GENDER EXPRESSION				
Attribute/Characteristic	Not at all difficult or uncomfortable	Somewhat difficult or uncomfortable	Extremely difficult or uncomfortable	Unsure
Male				
Female				
Trans*				
Gender nonconforming				

AGE				
Attribute/Characteristic	Not at all difficult or uncomfortable	Somewhat difficult or uncomfortable	Extremely difficult or uncomfortable	Unsure
Younger than me				
Same age				
Older than me				

RACE				
Attribute/Characteristic	Not at all difficult or uncomfortable	Somewhat difficult or uncomfortable	Extremely difficult or uncomfortable	Unsure
White				
Black				
Hispanic/Latino				
Asian				
Native American				
Other				

*Trans is the term used to capture the various identities that fall under the transgender umbrella including transgender, gender non-conforming, gender-queer, etc.

continued

Aspects of Diversity Self-Assessment
continued

SEXUAL ORIENTATION				
Attribute/Characteristic	Not at all difficult or uncomfortable	Somewhat difficult or uncomfortable	Extremely difficult or uncomfortable	Unsure
Gay				
Lesbian				
Bisexual				
Heterosexual				
Asexual				
Questioning				
Other				

SOCIOECONOMIC STATUS				
Attribute/Characteristic	Not at all difficult or uncomfortable	Somewhat difficult or uncomfortable	Extremely difficult or uncomfortable	Unsure
Poor/little access to resources				
Middle class/medium access to resources				
Wealthy/high access to resources				

continued

Aspects of Diversity Self-Assessment
continued

RELIGIOUS / SPIRITUAL BELIEFS				
Attribute / Characteristic	Not at all difficult or uncomfortable	Somewhat difficult or uncomfortable	Extremely difficult or uncomfortable	Unsure
Agnostic				
Atheist				
Buddhist				
Catholic				
Christian				
Hindu				
Islamic				
Jewish				
Spiritual but not religious				
Unsure/questioning				
Other				

continued

Aspects of Diversity Self-Assessment
continued

STAGE OF CHANGE

Attribute / Characteristic	Not at all difficult or uncomfortable	Somewhat difficult or uncomfortable	Extremely difficult or uncomfortable	Unsure
Pre-contemplation				
Contemplation				
Preparation				
Action				
Maintenance				
Lapse				

OTHER

Attribute / Characteristic	Not at all difficult or uncomfortable	Somewhat difficult or uncomfortable	Extremely difficult or uncomfortable	Unsure
Attractive				
Criminal background				
Difficulty learning/comprehending				
Engaged in treatment due to criminal justice involvement				
Experience as sex worker				
Mental health challenges				
Perpetrator of child abuse				
Perpetrator of domestic violence				
Purchased sex from sex worker				
Victim of physical abuse				
Victim of sexual abuse				
Voluntarily engaged in treatment				
Other				
Other				
Other				

New Employee Self-Assessment Facilitator's Guide

PURPOSE

For peer staff to increase self-awareness around strengths, challenges, and opportunities for growth as an employee

MATERIALS

New Employee Self-Assessment tool

TIME

2 hours

COST

Duplication of New Employee Self-Assessment Tool

DIRECTIONS

Ideally at the beginning of the supervisory relationship, the supervisor should offer this tool as a mechanism for peer staff to consider the impression they make in the workplace.

TIPS

Peer staff should be allotted time to complete this self-assessment in a thoughtful and meaningful manner, as opposed to rushing through the questions.

WRAP-UP

The completed self-assessment should serve as a guide for discussion in supervision and an opportunity to identify peer staff's strengths and opportunities to maximize those strengths, as well as to set goals around areas for growth and development.

NEW EMPLOYEE SELF-ASSESSMENT TOOL

1. What are your greatest strengths as an employee?
2. What are some areas for improvement as an employee? What are some strategies you can use to help you improvement in those areas?
3. What are some characteristics of a co-worker that enable you to work well with them?
4. What are some characteristics of a co-worker that make it challenging for you to work with them? What are some strategies you can use to help you to work effectively with these co-workers?
5. What are typical workplace tasks that you believe you are really good at?
6. What are some workplace tasks you struggle to complete? What are some strategies you can use to help you struggle less to complete them?
7. How would you describe your organizational skills? What do you do really well, and what are some opportunities for improvement?
8. How would you describe your communication skills? Where do you excel in communication with others, and where are some opportunities for improvement?
9. What was the greatest work-related challenge you have faced, and how did you overcome it?
10. What was your greatest leadership moment in the workplace and what made it the greatest?
11. What is some feedback that you've gotten from supervisors in the past related to opportunities for improvement? What did you do to improve?
12. Are there ways in which you prefer to receive constructive feedback?
13. When facing an obstacle or barrier in the workplace, how do you typically respond?
14. How difficult or challenging is it for you to ask others for help?
15. What would your past co-workers say were your greatest strengths?
16. What would your past co-workers say were your greatest challenges?
17. Please finish this sentence: I know I am at risk for compassion fatigue or burnout when…
18. What are some areas that you already know you could use some additional training in? What is your strategy for accessing that training?
19. What would be your personal mission statement?
20. What would you most want a new supervisor to know about you?
21. What would you most want new co-workers to know about you?

Supervisor's New Employee Orientation Checklist

With all there is to cover during the orientation process, it can be easy for supervisors to overlook an area for review or discussion with new peer staff. This checklist helps to ensure that you cover all desired areas.

✓	Area	Date
	Reviewed completed New Employee Self-Assessment	
	Reviewed completed Aspects of Diversity Self-Assessment	
	Reviewed completed Documentation Self-Assessment	
	Discussed supervision framework and peer staff roles and responsibilities in the supervisory relationship	
	Established work schedule, including process for requesting time off, flex time, etc.	
	Discussed time-management strengths and challenges	
	Discussed experience, strengths, and challenges with technology	
	Discussed process for giving regular performance feedback	
	Discussed interpersonal strengths and challenges	
	Established regular meeting days and times	
	Reviewed completed Self-Care Assessment	
	Discussed tasks or projects that peer staff is interested in working on outside of regular duties	
	Reviewed reasonable accommodations (if applicable)	
	Assigned peer mentor and discussed purpose and process	
	Discussed workplace Wellness Recovery Action Plan	
	Established process for addressing/interpreting policies and procedures as well as how to navigate and challenge traditional thinking	
	Scheduled shadowing opportunities	
	Discussed career goals and path	
	Introduced peer to larger service team, discussed role as a service team member, and explored partnership opportunities	
	Discussed the process for accessing resources and supplies	
	Other:	
	Other:	
	Other:	

Agency Assessment of Common Peer Staff Concerns Facilitator's Guide

PURPOSE

To explore the experience of peer staff in your agency with regard to some of the most common concerns reported by peer staff nationally.

MATERIALS

Agency Assessment of Common Peer Staff Concerns

TIME

2 hours (completion of self-assessment and discussion time)

COST

None

DIRECTIONS

Ask all staff or a sample of staff to complete the form, indicating their level of agreement on a scale of 1 to 4. It is important that both peer and non-clinical staff participate in this process. Doing so will ensure that peer staff are not scapegoated if their responses reflect that they are experiencing challenges within the organization. Also, it will be helpful for organizational leadership to see the differences or similarities between the perceptions of peer and other staff. If their perceptions are extremely dissimilar, this will indicate the need for increased dialogue and focused efforts to address the relevant issues. Staff should have the opportunity to complete the form privately to promote increased candor and transparency in their responses.

TIP

It is important that all staff feel safe in completing assessment with honesty and transparency. Supervisors can set the tone for this by authentically expressing the agency's desire to ensure that the voice of all staff is heard. Ensure staff understand that their feedback is instrumental in the agency's efforts to grow and sustain a recovery-oriented culture as well as a healthy, supportive work environment.

WRAP-UP

The outcome of this assessment should be discussed in a staff meeting and raised as an opportunity to solicit any additional feedback around the concerns of peer or other staff. This assessment and follow-up discussion can provide valuable information about what the organization is doing well and where there are opportunities for improvement. One follow-up question could be: "Which practices, processes, or policies contribute to the concerns that you identified?"

Agency Assessment of Common Peer Staff Concerns Scale

AGENCY ASSESSMENT OF COMMON PEER STAFF CONCERNS SCALE				
COMMON CONCERN Indicate your level of agreement with the following statements:	**1** Disagree	**2** Somewhat Agree	**3** Completely Agree	**4** Not Sure
Peer staff often feel isolated and experience difficulty integrating into the service team.				
We do not have an integrated team approach that incorporates both clinical and peer staff.				
Some staff distrust or feel threatened by peer staff.				
Peer staff drift toward performing traditional case management or clinical roles.				
Peer staff lack career advancement opportunities.				
The roles of volunteers and paid peer staff are not clearly differentiated.				
Peer staff are treated differently from other staff.				
The role of peer staff is unclear to non-peer staff.				
Peer staff experience time-management challenges.				
The role of peer staff is unclear to individuals seeking services.				
Training is inadequate and does not address key issues.				
The role of peer staff is unclear to clinical staff.				
Peer staff suggestions are not taken into consideration.				
Other concerns:				

Supervisor Tips for Documentation

- Identify specific times of the day and week dedicated to completing paperwork.
- Provide staff with laptops or tablet computer with remote access to complete updates in real time (especially when using electronic files).
- Facilitate group discussions on how to make completing the paperwork feasible.
- Ensure each peer support staff has a file for each individual served that contains all needed documentation. This will minimize the time spent organizing folders, files, and charts.
- Identify a structure for progress notes that will be easy to follow.
- Create templates that will be quick and easy for peer support staff to update.
- Create consistent standard tools: assessment form, recovery plan, check-in tool, group tool, referral form, MOU/MOA, etc.
- Ask peers to complete a self-assessment tool to explore their attitudes, beliefs, strengths, and challenges related to documentation. This tool can be used to help guide any training and support needs.
- Ensure that peer staff understand why the documentation is important beyond meeting regulatory requirements.
- Work with peer staff to identify documentation strategies based on their individual strengths and skills.

Documentation Self-Assessment Tool Facilitator's Guide

INTRODUCTION

Accurate documentation is a critical tool for delivering high-quality services and keeping necessary records.

PURPOSE

To allow peer staff to explore attitudes, beliefs, strengths, skills, barriers, and challenges related to documentation and to identify steps to addressing identified barriers and challenges. This self-assessment can then serve as a guide to discussing documentation in supervision.

MATERIALS

Documentation Self-Assessment Tool

TIME

1 hour

COST

Reproducing Documentation Self-Assessment Tool

DIRECTIONS

Peer staff will think about and write about what they perceive to be their attitudes and beliefs, strengths and skills, and barriers and challenges as related to documentation. Peer staff will then discuss and collaborate with their supervisor to complete an Action Plan to identify ways in which they can utilize their strength and skills alongside possible resources, supports and training to overcome any barriers or challenges.

TIPS

This tool should be revisited periodically in supervision to allow for regular assessments of progress as well as continued identification of any barriers or challenges related to documentation.

WRAP-UP

The completion of this tool by peer staff should serve as an opportunity for the supervisor and peer staff to have a conversation about documentation. As a result of the conversation, the supervisor and peer staff will share an understanding of the peer staff's strengths and challenges surrounding documentation as well as the areas for improvement. Both the supervisor and peer staff should walk away from the conversation with a clear understanding of next steps to enhance documentation practices.

Documentation Self-Assessment Tool

DOCUMENT SELF-ASSESSMENT TOOL	
Attitudes and Beliefs	What are my attitudes and beliefs about documentation?
	How do I see documentation as part of my job?
	Do I have fears or concerns related to documentation? If so, what are they?
Strengths and Skills	What strengths and skills do I possess that will aid in my documentation efforts (i.e., good computer skills, prior office experience, neat handwriting, quick learner)?
Barriers and Challenges	What barriers or challenges could get in the way of my documentation efforts (i.e., little computer experience, difficulties with time management, afraid to ask for help, unsure of how much detail is needed for notes, etc.)?
Action Plan	What support do I anticipate might be helpful?
	What accountability structure might be helpful?
	How can I use my strengths and skills to overcome any barriers or challenges?
	What else can I do to overcome challenges?

PURPOSE

To come together to discuss workplace wellness and self-care strategies. These events can be an extraordinarily helpful mechanism for added support and team building.

MATERIALS

Light refreshments (optional); agenda; handouts (as applicable); meeting space

TIME

1–2 hours, reoccurring monthly or more often, if needed

COST

Refreshments; costs associated with reproducing agenda and handouts

DIRECTIONS

Recovery Wellness Cafés are peer run and may be facilitated and attended by peer staff only. Ask one or two peer staff members to lead the effort, with supervisor support, as needed. The supervisor may need to be more involved with the start-up of the Recovery Wellness Cafés, including the tasks of identifying a meeting day and time, securing meeting space, ensuring peer staff are free to participate in the cafés (i.e., addressing staff coverage concerns), and supporting peer staff with creating an agenda.

Each Recovery Wellness Café should have an agenda (see sample agenda). Peer staff can alternate responsibility for bringing a self-care topic or strategy to share at each Recovery Wellness Café. It may be helpful for peer staff participants to be assigned to each of the following roles: creating the agenda for the next meeting, leading the café meeting, taking notes from the café about issues to share with others, and bringing a self-care topic or strategy to the next meeting.

In addition to being a source of sharing workplace wellness and self-care strategies and support, Wellness Recovery Cafés could also be used to promote recovery values and transformation. Peer staff could generate ideas and recommendations for further enhancing the recovery-oriented culture. These recommendations should be shared with Change Management Team and follow-up provided on any recommendation that are made.

WRAP-UP

Supervisors should check in with peer staff regarding the progress and benefits of Recovery Wellness Cafés. Peer staff should share any recommendations around promoting recovery values and transformation with the Change Management Team, and the Change Management Team should follow-up on any recommendations made. All Recovery Wellness Café participants ought to be invited to inform the content and direction of future cafés.

TIPS

Recovery Wellness Cafés can be designed for staff within an organization or could be designed to provide a networking opportunity to bring together peer staff from different organizations in the community to share promising practices, lessons learned, and self-care strategies. This may be particularly useful if the organizations do not have a large cohort of peer staff within each of them. If your agency does not have multiple staff in peer support roles, partner with other providers who also have peer support staff.

When peer staff are forming an agenda, attention should be paid to utilizing the café as an opportunity to provide and receive support as well as to discuss opportunities to promote recovery values and transformation in the agency and community.

Recovery Wellness Cafés

It is important to allow time for peers to attend these events and to encourage them to make attendance a priority. It is all too easy to allow attendance to wane when feeling the work pressures increase. But ongoing self-care helps sustain peer staffs' ability to provide quality services.

Recovery Wellness Café Sample Topics

- Review workplace Wellness Recovery Action Plans (WRAP)
- Complete and discuss Self-Care and Compassion Fatigue Assessments
- Introduce a monthly self-care strategy (healthy eating, physical fitness, mindfulness, recreation, social support, etc.)
- Share workplace successes
- Discuss a workplace challenge for the purpose of receiving feedback and support for overcoming it
- Share strategies and tools for time management
- Check in on long-term career goals
- Discuss how peer integration is going for both peer staff individually and the agency as a whole
- Discuss continuing education goals
- Share strategies for balancing personal recovery and work-place demands
- Generate ideas and recommendations for further enhanc-ing the recovery oriented culture to be shared with Change Management Team

Recovery Wellness Café Sample Agenda

1. Welcome and Check-In
   (10 mins)
2. Self-Care Strategy of the Month: Healthy Eating
   (15 mins)

   Keisha Smith to present on benefits of healthy eating and recipes she has used for smoothies on the go

   Wrap up with asking for a volunteer to present next month
3. Compassion Fatigue Self-Assessment and Discussion
   (20 mins)

   Group members will complete brief compassion fatigue assessment and discuss results, as comfortable, with the group
4. Other Items/other topics group members wish to bring up
   (5 mins)
5. Close

Self-Care Assessment

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.

Using the scale below, rate the following areas in terms of frequency:

5 = Frequently 4 = Occasionally 3 = Rarely 2 = Never 1 = It never occurred to me

PHYSICAL SELF-CARE

___ Eat regularly (e.g., breakfast, lunch and dinner)

___ Eat healthy

___ Exercise

___ Get regular medical care for prevention

___ Get medical care when needed

___ Take time off when needed

___ Get massages

___ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun

___ Take time to be sexual—with yourself, with a partner

___ Get enough sleep

___ Wear clothes you like

___ Take vacations

___ Take day trips or mini-vacations

___ Make time away from telephones

___ Other:

PSYCHOLOGICAL SELF-CARE

___ Make time for self-reflection

___ Have your own personal psychotherapy

___ Write in a journal

___ Read literature that is unrelated to work

___ Do something at which you are not expert or in charge

___ Decrease stress in your life

___ Let others know different aspects of you

___ Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings

___ Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance

___ Practice receiving from others

___ Be curious

___ Say "no" to extra responsibilities sometimes

___ Other:

continued

Self-Care Assessment *continued*

EMOTIONAL SELF-CARE

___ Spend time with others whose company you enjoy

___ Stay in contact with important people in your life

___ Give yourself affirmations, praise yourself

___ Love yourself

___ Re-read favorite books, re-view favorite movies

___ Identify comforting activities, objects, people, relationships, places and seek them out

___ Allow yourself to cry

___ Find things that make you laugh

___ Express your outrage in social action, letters and donations, marches, protests

___ Play with children

___ Other:

SPIRITUAL SELF-CARE

___ Make time for reflection

___ Spend time with nature

___ Find a spiritual connection or community

___ Be open to inspiration

___ Cherish your optimism and hope

___ Be aware of nonmaterial aspects of life

___ Try at times not to be in charge or the expert

___ Be open to not knowing

___ Identify what in meaningful to you and notice its place in your life

___ Meditate

___ Pray

___ Sing

___ Spend time with children

___ Have experiences of awe

___ Contribute to causes in which you believe

___ Read inspirational literature (talks, music, etc.)

___ Other:

WORKPLACE OR PROFESSIONAL SELF-CARE

___ Take a break during the workday (e.g., lunch)

___ Take time to chat with co-workers

___ Make quiet time to complete tasks

___ Identify projects or tasks that are exciting and rewarding

___ Set limits with your clients and colleagues

___ Balance your caseload so that no one day or part of a day is "too much"

___ Arrange your work space so it is comfortable and comforting

___ Get regular supervision or consultation

___ Negotiate for your needs (benefits, pay raise)

___ Have a peer support group

___ Develop a non-trauma area of professional interest

___ Other:

BALANCE

___ Strive for balance within your work-life and workday

___ Strive for balance among work, family, relationships, play, and rest

Professional Quality of Life Scale

Compassion Satisfaction and Compassion Fatigue; (ProQOL) Version 5 (2009)

When you support people you have direct contact with their lives. As you may have found, your compassion for those you support can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a peer support provider. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

5 = Very Often 4 = Often 3 = Sometimes 2 = Rarely 1 = Never

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I support.
___ 3. I get satisfaction from being able to support people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I help.
___ 7. I find it difficult to separate my personal life from my life as a peer support provider.
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I support.
___ 9. I think that I might have been affected by the traumatic stress of those I support.
___ 10. I feel trapped by my job as a peer support provider.
___ 11. Because of my support, I have felt "on edge" about various things.
___ 12. I like my work as a peer support provider.
___ 13. I feel depressed because of the traumatic experiences of the people I support.
___ 14. I feel as though I am experiencing the trauma of someone I have supported.
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with supporting techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a peer support provider.
___ 20. I have happy thoughts and feelings about those I support and how I could help them.
___ 21. I feel overwhelmed because my caseload seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I support.
___ 24. I am proud of what I can do to help.
___ 25. As a result of my peer support work, I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a peer support provider.
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

COMPASSION SATISFACTION _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

BURNOUT _____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

SECONDARY TRAUMATIC STRESS _____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, fieldwork in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

continued

ProQOL Scoring *continued*

In this section, you will score your test so you understand the interpretation for you. To find your score on each section, total the questions listed on the left and then find your score in the table on the right of the section.

COMPASSION SATISFACTION SCALE

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____

TOTAL : ____

The Sum of My Compassion Satisfaction Questions Is	So My Score Equals	And My Compassion Satisfaction Level Is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

BURNOUT SCALE

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are not happy so you reverse the score.

You wrote	Change to
1	5
2	4
3	3
4	2
5	1

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____

TOTAL : ____

The Sum of My Burnout Questions Is	So My Score Equals	And My Burnout Level Is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

SECONDARY TRAUMATIC STRESS SCALE

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____

TOTAL : ____

The Sum of My Secondary Trauma Questions Is	So My Score Equals	And My Secondary Traumatic Stress Level Is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

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