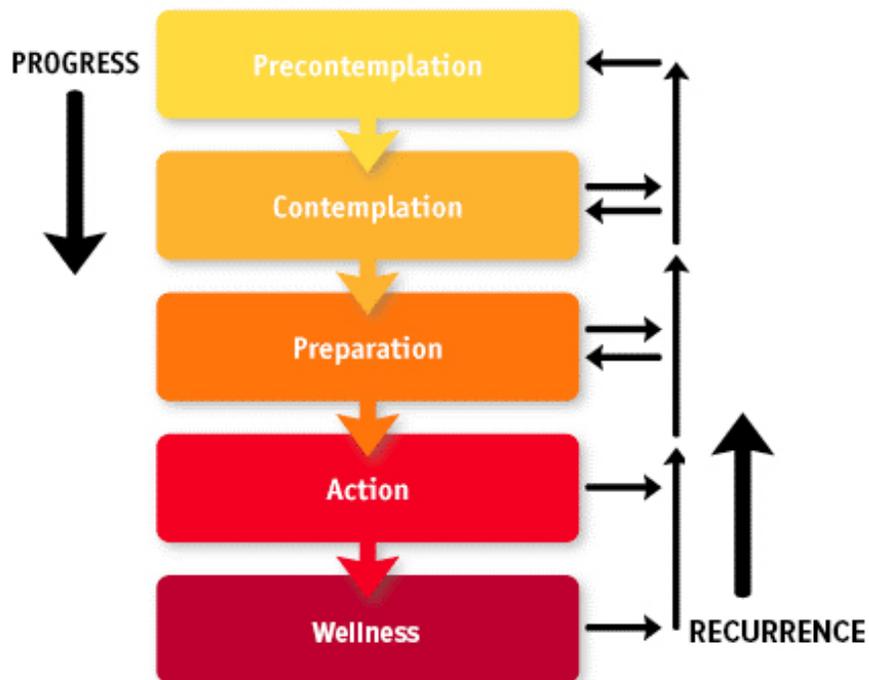




Office of Alcoholism and Substance Abuse Services

Peer Integration and the Stages of Change ToolKit



OASAS has put together a useful and comprehensive toolkit that establishes the currency of peers in the workforce. It's "how-to" format underscores the value of lived experience in engagement and recovery activation, demonstrating how peer roles can emphasize recovery principles and values, transform organizational culture, and achieve recovery outcomes. –

Tom Hill

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**Office of Alcoholism and
Substance Abuse Services**

ARLENE GONZÁLEZ-SÁNCHEZ, M.S., L.M.S.W.
Commissioner

May 2018

Dear Provider:

We are pleased to share with you the attached New York State Peer Integration Toolkit which has been developed to inform and assist you in integrating peer services into your service delivery system. Building the infrastructure to support peer services is a major part of the expansion of Recovery Supports underway in New York State.

Peer services offer a way for people with lived experience to provide support to others in similar circumstances. The use of peer services is recognized as an effective, evidence-based approach. Consequently, the expansion of peer services is an important part of the Governor's multi-pronged approach to addressing substance use disorders in New York State.

The New York State Peer Integration Toolkit has been designed as an in-depth tool to assist providers of NYS OASAS Outpatient services, to integrate peer services using the Stages of Change model. Our hope is that you will find the Peer Integration Toolkit useful wherever you are in the peer integration process.

Thank you for your dedication to the field of addiction and your service to the people of New York State.

Sincerely,

A handwritten signature in blue ink that reads "Arlene González-Sánchez".

Arlene González-Sánchez
Commissioner

Thank you to the Sponsors and Contributors of this Toolkit

The New York State Peer Integration Toolkit has been developed through a collaboration of the New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS), consultants, and a group of providers of substance use services committed to pursuing the integration of peer services in New York State. These providers participated in a series of focus groups that informed on issues of most concern to them, in the provision of peer services, and began a learning collaboration that focused on the integration of peer services in outpatient settings. The toolkit has been developed with support of the Substance Abuse and Mental Health Services Administration's *Bringing Recovery Supports to Scale grant*.

We would also like to thank Governor Andrew M. Cuomo for recognizing the need for a Recovery Oriented System of Care (ROSC) for individuals, families and communities in New York State. OASAS would also like to thank the many Addiction Treatment Providers who contributed time and energy to producing this toolkit.

We are grateful for the founders of the Recovery Movement and we acknowledge them for being among those laying the foundation for the development of ROSC across the country, over the past 20 years. Several of these founders have weighed in to offer encouraging words to the providers in New York State that are in the pursuit of integrating peer services—a key tenet of ROSC. Please see their comments throughout this toolkit.

- **William L. White:** William White has authored or co-authored more than 400 articles, monographs, research reports and book chapters and 20 books. His book, *Slaying the Dragon* received the McGovern Family Foundation Award for the best book on addiction recovery. His latest book is *Recovery Rising* a retrospective on addiction treatment and recovery advocacy.¹
- **Thomas A. Kirk, Jr., Ph.D.:** Dr. Tom Kirk is the former Commissioner of the Connecticut Department of Mental Health and Addiction Services (DMHAS), Dr. Kirk's ten-year leadership of DMHAS transformed it into a nationally recognized recovery-oriented system of care, notable for its recovery policies, practices, financing and outcomes. In addition, he has since mentored other recovery leaders and groups in the United States and Canada.
- **Arthur Evans, Ph.D.:** Arthur Evans is the newly appointed CEO of the American Psychological Association and former Commissioner of Philadelphia's \$1.2 billion behavioral health care system. Dr. Evans led the realignment of Philadelphia's treatment philosophy, service delivery models and fiscal policies to improve long-term recovery outcomes and increase the efficiency of the service system.
- **Lionetta Albright:** Lionetta Albright is the former Executive Director of the Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC) at the University of Illinois Jane Addams College of Social Work and led the ATTC Network in Recovery Management and Recovery-Oriented System Transformation efforts for the field. She also led her ATTC's ROSC efforts in Africa to train and build capacity within the substance use systems and recovery community in Tanzania and Zanzibar, Africa. She continues to consult and train states, systems and communities around recovery management and all components of ROSC transformation including peers and recovery support services.

¹ <http://www.williamwhitepapers.com/blog/2017/09/recovery-rising-a-retrospective-of-addiction-treatment-and-recovery-advocacy.html>

- **Tom Hill:** Tom Hill is the Vice President of the Addiction and Recovery National Council for Behavioral Health. Mr. Hill is a sought after national thought leader in addiction recovery advocacy and peer services.
- **Luke Bergmann, Ph.D., Assistant Vice President, NYC Health + Hospitals Corporation:** Dr. Bergmann has been a leader in the national recovery movement, playing a major role in laying the foundation for the integration of peer services in New York City.
- **Andre Johnson, CEO of the Detroit Recovery Project:** Andre Johnson was honored by the White House in 2016 as a “Champion of Change for Prevention, Treatment and Recovery,” for life changing work. From Detroit to his work overseas, Andre has chosen to dedicate his talents to serve the American people.
- **Walter Ginter:** Walter Ginter is the founding Project Director of the Medication Assisted Recovery Support (MARS™). Project MARS™ is designed to provide peer recovery support to persons whose recovery from opiate addiction is assisted by medication. Walter is an international expert on medication assisted recovery and the country’s foremost patient advocate.
- **Laura Langner, CEO, Complete Compliance Solutions:** Laura has been a major supporter of Recovery and the Peer movement in New York State. She was also a main writer and developer of the New York State Peer Integration Toolkit and accompanying training.

“The integration of peer recovery support services within addiction treatment programs is a clinically and cost-effective strategy of extending models of acute biopsychosocial stabilization to models of sustained recovery management that address the support needs of individuals and families across the multiple stages of recovery. Such services hold great promise in shortening addiction careers (via recovery-focused community education and assertive outreach), enhancing treatment engagement and retention, and enhancing long-term recovery outcomes via post-treatment monitoring, stage-appropriate recovery education and support, and, if and when needed, early re-intervention.”

– **William L. White**



Peer Integration and the Stages of Change

Fundamental to assisting individuals in Behavioral Health is working with them to identify where they are in the stages of change. Knowing this, allows everyone involved to develop a plan of care that will demonstrate the need for change and outline a process to enhance the likelihood of success. This is no different for an organization. As populations, services, staffing and revenue streams change so must organizations. To effectively implement change, the organization would need to evaluate their current stage of change about the integration of peer services (pre-contemplation, contemplation, preparation, action or wellness). Ultimately, it is about sustainability, their ability to adapt and thrive in a changing environment.

Pre-contemplation

While this entire toolkit is designed for providers in New York State who are interested in learning more about Peer services and most importantly as a tool for those who are in the process of implementing peer-to-peer services, we are approaching this toolkit through the *Stages of Change* model which the provider system is very well acquainted with. This model fits the findings of focus groups that we had with providers that informed this process and who candidly shared their thought on peer services, which fell into three main categories:

1. Did not see the need for hiring peers for various reasons
2. Would like to hire peers, but they either did not understand the process to do so, did not have buy-in from the executive level and/or could not see the fiscal feasibility of hiring peers
3. Were in the early stages of integrating peers, but still needed assistance to do so

In this section, we will provide information for provider staff who work in agencies that are in pre-contemplation. This stage may be characterized by the executive/upper management staff not being committed to and or understanding the value of peer services or the risks of not integrating this best practice recovery support. The entire toolkit including this section should be read by all seeking to or currently implementing peer services, as it can also be used as a refresher to understand why peer services are so important to the provision of substance use disorder (SUD) services and to national policy. It is our hope that it will provide solid reasoning for implementing peer services into your organization's service array.

The History and Case for Peer-to-Peer Services

There have been substantial advances in the very important area of the delivery of peer services. In fact, the phrase *Peer Services Have Arrived* has come to define the status of the current peer movement in New York State. This toolkit will begin in this section to lay out the causal factors that led to this ascent of the concept of peer services and build the case for a substantial integration of peer-to-peer services in New York State. We will first look at why peer services are very important now for persons in recovery from substance use and mental health issues; for providers in these systems; and other human services fields in New York State and nationally. It is crucial to understand the importance of peer-to-peer services, as a significant recovery support, from both a human service and a fiscal vantage point.

As SUD professionals, we all are aware of the growing complexity and profound devastation that addiction can bring, however, the current statistics below indicate the profoundly negative impact that the current drug epidemic has on the nation, particularly its impact on our youth and their futures.

The Face of the Current U.S. Drug Crisis

- **Child Welfare:** Children whose parents suffer from addiction are at higher risk of increased mortality, attempted suicide, teenage pregnancy and unemployment as adults.²
Wide spread abuse of powerful opioids has pushed U.S. overdose death rates to all-time highs. It has also traumatized tens of thousands of children. The numbers of children in foster care in many states has soared.³ As of 2012, the federal government says, one baby is born suffering from opioid withdrawal every 25 minutes.⁴
- **Homelessness:** 31% of America's homeless suffer from drug use including alcoholism⁵
- **Health:** People who suffer from addiction often have one or more active medical issues, which may include lung or cardiovascular disease, stroke, cancer, and mental disorders⁶
- The United States of America is in the grip of an unprecedented epidemic of drug addiction. In 2014, more than 47,000 people were killed by an overdose—that is more than were killed by guns, or died in traffic accidents. Each day, 125 people take their last hit, and millions more are leading diminished lives governed by the need to "get well" before all else.⁷
- During 2107, the Opioid crisis was declared a national public health crisis.⁸
- Drug overdose deaths in 2016 most likely exceeded 59,000, the largest annual jump ever recorded in the United States... deaths rose 19 percent over the 52,404 recorded in 2015. And all evidence suggests the problem has continued to worsen in 2017.⁹
- **Human Resources:** 67% of HR professionals believe that addiction is one of the most serious issues they face in their organization.¹⁰

Substance Use Fiscal Impacts and Outcomes

Not only are there profound health and human tragedy connected to SUD, but the abuse of tobacco, alcohol, and illicit drugs is costly to our Nation, exacting more than \$740 billion annually in costs related to crime, lost work productivity and health care.

(NIDA, Trends and Statistics, April 21, 2017)

² Face, it Together, <http://www.wefaceittogether.org/it-s-a-disease/costs-of-addiction>

³Jeanne Whalen, "The Children of the Opioid Crisis," *The Wall Street Journal*, December 16, 2016.

⁴Katharine, Q., Seely, "New Mothers Derailed by Drugs Find Support in a New Hampshire Home," *The New York Times*, Dec. 11, 2016.

⁵ National Institute on Drug Abuse, <https://archives.drugabuse.gov/about/welcome/aboutdrugabuse/magnitude/>

⁶ National Institute of Drug Abuse, <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/addiction-health>

⁷ No pain, no gain: how big pharma hooked America. <http://www.andrewpurcell.net/?p=2409>

⁸ <https://www.usatoday.com/story/news/politics/2017/10/26/exclusive-trump-declare-public-health-emergency-opioid-crisis-partial-measure-figh/796797001/>

⁹ Josh Katz, "Drug deaths in America are rising faster than ever," *The New York Times*, June 5, 2017.

¹⁰ Face, it Together, <http://www.wefaceittogether.org/it-s-a-disease/costs-of-addiction>

***(if this or any other link does not work, please copy and paste into your browser.)**

- Health care, (with Medicaid costs being the largest cost in this category) are a significant problem that the country has had a hard time reigning in.
- Addiction is a serious driver of health care costs, estimated at \$215 out of 428 billion annually (53 percent).
- The economic cost of addiction in the United States is twice that of any other disease affecting the brain, including Alzheimer's disease.

The Triple Aim, of the Obama Administration Affordable Health Care Act, is: 1) improving care, 2) improving health, and 3) reducing per capita costs. This was instituted to respond to the issue of the health care costs and the need to provide better care and to achieve better health outcomes. In addition, Medicaid costs and the issues of substance use were also a major issue for New York State.

Health Care in New York State

Our costs for Medicaid are well over twice the national average. The two larger states, California and Texas, have almost three times our population but combined, they spend only a bit more than New York on Medicaid.¹¹ Medicaid costs in New York State have served to be a major driver for change. When Governor Cuomo took office, state-share Medicaid spending was on path to grow by 13 percent. In response, he created the Medicaid Redesign Team (MRT) in January 2011 with the express purpose of developing a multi-year action plan that would achieve the national Triple Aim: improving care, improving health, and reducing per capita costs. New York State submitted a groundbreaking new Medicaid 1115 waiver amendment. The waiver has allowed the state to reinvest in its health care infrastructure. One essential component of the waiver is the use of savings to invest in new models of care, including expanded recovery supports.

Peer Services = Better Care, Better Health and Lower Costs

Peer-to-peer services emerged in the early 2000s as an idea whose time had come not just to take its place on the stage, but to play a major role in addressing SUD and mental health issues. Serious thought was given to how to reform health care's runaway costs, to achieve the triple aim of better health, better care and lower costs. In view of the deadly human tragedy, imperiling the future of the nation, there is an urgent need to use every tool and resource available to address the issue of the growing shadow that SUD casts over the future of the nation. Peer-to-peer services are part of the plans in New York State and the nation to address these issues as they are best practice, having the ability to reach our target population to deliver authenticity, empathy and hope in a way that will achieve better outcomes for persons in recovery and thus, the provider system.

¹¹ The Henry J. Kaiser Family Foundation, 2015

Peer-to-peer services are a part of a new recovery paradigm shift which exists. This shift includes: the new recovery advocacy movement, new recovery support institutions, emergence of recovery as a new organizing paradigm for policy and practice, and efforts to shift acute and palliative care models of interventions to models of sustained Recovery Management nested within ROSC. Peer-to-peer support services can be used at every stage of recovery:

- Pre-Recovery — Recovery Centers, and peer outreach
- Recovery initiation and stabilization — Detox, Stabilization Element of Care, Outpatient, Faith-Based, Medication Assisted, In-patient services, Rehabilitation, etc. Also, connecting to the next level of care.
- Transition to recovery maintenance — Medication-Assisted, Rehabilitation Element of Care, Outpatient services
- Elevation of quality of personal/family life in long-term recovery — reintegration into family and community.
- Efforts to break intergenerational cycles of addiction — reintegration into family and community

The following is selected evidence from research on the ability of peer services to produce better outcomes that will equate to better engagement, retention and better census for providers. More importantly, better outcomes for people suffering from the SUD. Following are specific statements on the outcomes and use of peer services:

Evidence-Based Research Outcomes

- The Centers for Medicaid & Medicare (CMS) stated, “Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State’s delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services.”¹²
- Peer providers can fill a gap that often exists in both formal and informal treatment for individuals with substance use disorders (SUD) by focusing on recovery first and by helping to rebuild and redefine the individual’s community and life. Peer providers have a unique perspective and ability to empathize with those in treatment for SUD. Peer providers also often offer many non-clinical roles that might help support recovery activities.¹³
- A study of peer recovery support programs for individuals with co-occurring serious mental illness and substance use disorders found longer stays in the community before re-hospitalization compared with a matched-sample comparison group of individuals who were not in the program; overall, fewer participants in the peer recovery group were hospitalized.¹⁴

¹² Department of Health and Human Services, Centers for Medicaid & Medicare;

http://cosb.countyofsb.org/uploadedFiles/admhs_new/resources/Systems_Change/Peer_Action_Team/CMS-8-15-07.pdf

¹³ What is the Evidence for Peer Recovery Support Services;

¹⁴ Sharon Reef, Ph.D., et. al., “Peer Recovery Support for Individuals with Substance Use Disorders: Assessing the Evidence,” Psychiatric Services, 2014

- In a research study of peer recovery support, the group that received peer recovery support reported higher satisfaction with specific services, including perceptions of a greater level of empathy.¹⁵
- Historically drug and alcohol addiction has been addressed through intense professional services during acute episodes. While effective in significantly reducing substance use, relapse rates are generally high.^{16 17}
- Most studies reported statistically significant findings indicating that participants receiving the peer intervention showed improvements in substance use, a range of recovery outcomes, or both. These findings suggest that peer interventions positively impact the lives of individuals with substance use disorder.¹⁸ Peer support has been shown to play an influential role in health and health care delivery. Peers are welcomed as reliable sources of knowledge and lived experiences. They also provide emotional, social and practical assistance in a culturally and linguistically appropriate manner.¹⁹

Substance Use Disorder can be a chronic health care condition with significant human and fiscal health costs. For New York State to ultimately control health care costs, it must ensure that better care is provided, resulting in improvements in overall health. One of the biggest problems with the state's health care system is that it is not successful in ensuring that complex, high-cost populations obtain the coordinated care they require. One of the most alarming issues related to addiction is its profoundly negative impact on each member of the family, and communities across New York State and the nation. Particularly disturbing is the impact that it has on children and adolescents. Peer-to-peer services is an effective and proven tool to use in a time of such devastating proportions as the current and ongoing drug epidemic. It has a role to play that can be beneficial to the people we serve, the provider system and the State of New York in reaching our triple aim of assisting in the provision of better care, better health and lower costs. In addition, as the behavioral health system transitions to Medicaid Managed Care within the treatment system, value-based treatment and good outcomes for patients are crucial.

¹⁵ Sharon Reaf Ph.D. "Peer Recovery Support for Individuals with Substance Use Disorders."

¹⁶ Ellen L. Bassuk, M.D., Justine Hanson, Ph.D. Ellen L. Bassuk, M.D., Justine Hanson, Ph.D. "Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review," *Journal of Substance Abuse Treatment*; 63 (2016) 1–9.

¹⁷ McLellan et al, 2000; White, 2008; Dennis & Scott, 2007

¹⁸ White, 2009 and Reif, et al. 2014

¹⁹ Center for Health Law & Policy Innovation at Harvard Law School, NCLR, Peers for Progress, and the Society of Behavioral Medicine "Call to Action: Integrating Peer Support in Prevention and Health Care Under the Affordable Care Act," Society for Behavioral Health Medicine, 2014.

“Overdose epidemic. Complex fiscal, service and care delivery challenges in the addiction and overall healthcare system. It’ll all work out. It always does.” Enough sense of urgency? Vision? Outcomes? NO! If we partner with individuals/families who have experienced addiction and recovery, design and deliver a mix of outcome-based peer-to peer services within an integrated healthcare model, the answer is YES! Healthy people and communities! Let’s make it happen!” – **Thomas A. Kirk, Jr., Ph.D.**



Contemplation

Understanding Peer Services

So, you have started thinking about the feasibility of adding certified peer services to your service array. You may be wondering where to start. Many providers at this point start thinking of fiscal issues. How much can I bill for this service, is it fiscally feasible? These are legitimate concerns. However, it is not the place to start. Fiscal considerations aside, an investment in your service array must start from a place of complete understanding of the service. In the case of integrating peers, many people have misconceptions that can lead to failure in integrating peer services. These misconceptions include:

1. This is nothing new, we have used people in recovery for years in entry-level positions for overnight and weekend house managers, CASAC-T, etc.
2. I am a person in recovery. I understand peer services.
3. There is little difference between peer and clinical services.
4. Why do we need to integrate peers when individuals can access a sponsor?

The use of peer dates to 18th and 19th century mutual aid groups and their use in 19th century inebriate homes and addiction cure institutes²⁰ and today persons in recovery are found in all levels of services within the substance use system. However, the application of the peer-to-peer recovery framework is very different from a counselor or a sponsor. Peer services insertion into the selections of recovery supports is relatively new. The recovery coach is a role between two other recovery support persons: the recovery support group sponsor and the SUD counselor. However, while these roles seem similar, there is a clear distinction, that is very important to be understood when integrating peer-to-peer services.

Differentiating the roles of the Peer Advocate, Sponsor and Addiction Counselor

Peer Advocate (CRPA)	Sponsor	Addiction Counselor
<p>Defined: In most cases, CRPA is a person with lived experience from substance use issues who has received specialized training and supervision to guide and support others who are experiencing similar substance use issues. They work as representatives of formal service organizations where they are bound by accreditation, licensing and funding considerations.</p>	<p>A sponsor is an unpaid peer helper who agrees to be a resource and support person for newcomer in a 12-step program. The Sponsor helps the newcomer learn about the program, work through the Steps, and serves as a willing listener when the sponsee needs to talk, and offers his/her lived experience. The sponsor and sponsee often become friends.</p>	<p>An addiction counselor is a person, who is bound by ethical legal requirements such as confidentiality in the counseling relationship and has proof of expertise in clinical areas. Counselors teach people how to modify their behaviors and work towards full recovery. They are bound by licensing, and funding considerations.</p>
<p>Relationship: Assists in the development of a Recovery Plan. Focuses on now and the future. Assists in accessing emotional, informational affiliation and instrumental supports.</p>	<p>Source of continual support based on reciprocity; gives advice</p>	<p>Hierarchical, clinical relationship. Focuses on resolving issues of the past. Based on forming a therapeutic alliance.</p>
<p>Key descriptive words: Identify, engage, encourage, motivate link, support, advocate, orient, accompany</p>	<p>Supporter, guide, teacher, mentor helper, offers advice, encourager</p>	<p>Representative, Clinical resource, link</p>

²⁰ White, W. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

Remuneration-Certified Peer Advocates are Medicaid billable and are utilized in paid clinical settings.

Sponsors are paid by maintaining their recovery.

Counselors are paid.

What Are Peer Recovery Support Services?

Peer Support services fall into four categories—Emotional, Informational, Instrumental (concrete) and Affiliational.

Type of Support	Description	Peer Support Service Examples
Emotional	Demonstrate empathy, caring, or concern to bolster person's self-esteem and confidence.	Peer mentoring Peer-led support groups
Informational	Share knowledge and information and/or provide life or vocational skills training.	Parenting class Job readiness training Wellness seminar
Instrumental	Provide concrete assistance to help others accomplish tasks.	Child care Transportation Help accessing community health and social services
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.	Recovery centers Sports league participation Alcohol and drug-free socialization opportunities.

Above are the scope of peer-to-peer support services. These services can be provided within a Recovery Center where they should be developed according to the needs of the community where they are peer informed and led by peers. Recovery Coaches can also be used within the clinical settings as non-billable peer services in accordance with the Recovery Plan. Please note that community-based peer supports, for example, Recovery Centers, have a greater emphasis on affiliational supports than do clinical programs which provide all types of support, but have a strong focus on instrumental (concrete supports). They often have holiday events, allow faith-based supports to be held in the Center as well as drug-free events open to the Recovery community. Here are some services that peers can provide with their related category:

Billable Services

Developing Recovery Plans/Billable Service	Type of Peer-to-Peer Support Services
1. Raising awareness of existing social and other support services	Affiliation
2. Modeling coping skills	Emotional
3. Assisting with applying for benefits	Instrumental
4. Accompanying clients to medical and other appointments	Emotional/Instrumental
5. Providing non-clinical crisis support, especially after periods of hospitalization or incarceration	Emotional/Concrete
6. Accompanying clients to court appearances	Emotional/Instrumental
7. Working with participants to identify strengths	Emotional
8. Linking participants to formal recovery supports	Instrumental
9. Educating program participants about various modes of recovery	Informational
10. Travel training – to use public transportation independently	Instrumental

Volunteer vs. Paid Positions for Peers

The rapidly growing peer workforce is an integral part of the behavioral health transition. In addition, Peer recovery supports are essential to a Recovery Oriented Systems of Care. The development of peer supports includes both paid staff and volunteers. There are good reasons to hire peers in both volunteer and paid positions. For sustainability and effective outcome-oriented services, peers must be intentionally integrated into a well thought out process that benefits the peer and the agency. Providers should think about how they can integrate paid and volunteer peers, as both add value to an agency.

People, including those in the SUD and mental health systems, choose to volunteer for a variety of reasons. For some, it offers the chance to give something back to the community or make a difference to the people around them. For others, it provides an opportunity to develop new skills or build on existing experience and knowledge, also to stay active and relevant in the field of their interest. Surveys of peers within the SUD system show that peers overwhelmingly view peer services as not only a way to give back, but as a career path. There are benefits for peers in both systems, to provide volunteer services to an end goal, as well as, for peers looking to move into paid positions. For peers in the SUD system, volunteering at an agency offers a way to gain the 500 hours of experience needed to become a Certified Peer Recovery Advocate. Volunteer peer services are good for both the agency and the individual. For a provider of Outpatient SUD services, it can give the agency the ability to focus Certified peer staff on certain tasks (including billable services) while focusing volunteer staff on other needed activities. However, these activities are of equal importance to the individuals that are served, the peer, and the agency. Preparing to add peer volunteer staff parallels the same process as adding paid peer staff. The provider agency will need to take the following steps ²¹:

- **Create a Plan for the Volunteer Program:** Complete a needs assessment around the needs of the agency related to peer supports.
- **Recruit and place volunteers**
- **Orient and train volunteers (and all staff):** Your peer must have recovery coach training as a requirement, and there must be ongoing training as there is with paid staff.
- **Evaluate the Volunteer**

Here are some of the recovery supports that a volunteer can perform, after they have been trained:

- Emotional: recovery coaching
- Informational: Peer led groups: housing, accessing social services, accessing health care, family issues, women and or men's issues, faith, life skills, etc.
- Concrete: Accessing social services or child care
- Affiliational: Providing alcohol and other drug-free holiday and recreational events and activities

There are similarities and differences between paid and of volunteer staff. Both types of peers share more similarities than differences, and both bring value to an organization:

- Of course, paid peers are compensated monetarily for their time and work. Volunteers do not receive monetary compensation.
- Paid staff are usually between the ages of 18 and 67. Volunteers do not have an age limit. Therefore, providers may want to pay special attention to engaging peers who have retired and want to give back.

²¹ <http://blog.handsonsuburbanchicago.org/?p=139>

- Work hours are treated different for volunteers and paid staff. Therefore, programs should look to have both paid and volunteer staff.
- Both paid staff and volunteers need clear, frequent, two-way communication. There needs to be an established system of information sharing between full-time employees and part-time volunteers. This is important because part-time volunteers will generally not be present at the agency each day. It is crucial for non-profit managers to understand that clear communication on a frequent basis will ensure that all are on the same playing field. Everyone wants to feel that what they are doing is valued whether they are getting paid for it or not. It is important to ensure that volunteers feel a sense of ownership over their work and inclusion in the organization.
- Certified staff are certified for several reasons, but non-certified peer volunteers will not be able to be utilized in the Medicaid billable services.
- Volunteers expect flexible schedules and not to be reprimanded when they miss work.

Organizational staff should:

- Know what the peer is looking for. Is it to solely give back, or is the peer looking for volunteer work experience and looking ultimately for a paid position?
- Map out how the agency can meet the needs and strengthen the peer, for example, work experience, training including peer leadership training, and/or positive affiliation and a chance to give back.
- Develop a peer career path for both paid and volunteer staff. Are there opportunities for advancement for the peer or is there training or other support? Do we want to develop an Alumni Association and gear this effort towards opportunities to volunteer as recovery coaches?
- Providers should also talk to other agencies about their experiences that have been successful with paid and volunteer peers.

Successful organizations share the following characteristics:

- Effective sharing of goals—a healthy organization shares its business goals with employees at every level of the organization including volunteers
- Teamwork
- High employee morale—endeavors to develop an environment of wellness
- Offers training opportunities
- Leadership—good organizational leadership skills keep organizations in tune with the business environment and outcome needs. This is key to fiscal viability and survival in the current behavioral health transition.
- Addresses poor performance
- Understands risks
- Adapts to opportunities and changes

Ongoing and effective volunteer management will entail similar activities to employing paid staff—ensuring that all staff understand the role of peer services, a good job description, finding the right person for the right task, ongoing training and supervision, clear two-way communication and evaluation and monitoring. In addition, the most effective agencies create a wellness environment. The organizations with the greatest success are managing to shift people’s relationship with health from one where health is something thought about and “practiced” annually at the doctor’s office, to one where health is practiced daily through small lifestyle habits.²²

²² <https://hbr.org/2014/03/what-great-corporate-wellness-programs-do>

“Peers often share a common culture, language and deep understanding of the problems that people in their communities’ experience. For those reasons, peers can promote recovery, foster resilience and build on strengths to support community integration and help others lead more fulfilling lives. Peer services and support can complement and enhance other health services. Peer specialists have been demonstrated to improve quality of life, promote wellness, increase retention, enhance treatment adherence, and improve coping skills. Peers are an essential part of an effective and efficient service system.” – **Arthur Evans, PH.D**



Peer Support Values

Recovery seems to be a simple framework as compared to the clinical theory. However, Recovery, and its foundational shift in how we provide services towards better outcomes requires a paradigm shift in thinking. That is a key reason that people think that there is very little difference between the services they have provided for years often using persons who may have come through treatment, but now provide services as a residential aid, CASAC-T or CASAC and the services of a peer provider. The very crucial difference which must be understood by all staff are the **values** that undergird peer services. Please take note of the key peer support values which must be part of an intentional plan to implement *authentic* peer services. Implementing peer services requires creating an environment defined by the following peer values:

- **Self Determination:** Self-directed care is the belief that, people should have control over decisions regarding their lives and that with support and access to information they can manage their own care. In a recovery-oriented system of care, individuals should be encouraged to determine their recovery goals.
- **Choice:** Making a choice is an act of selecting or deciding when faced with two or more possibilities. In recovery, the concept of choice means the person makes the decisions that support their recovery such as goals, pathway, time and even the decision to choose or not to choose recovery.
- **Dignity of Risk and Right to Fail:** Dignity of risk is a term used to express the reality that everything a person does has an element of risk, and every opportunity for growth carries with it the potential for failure. As human beings, we learn through a process of trial and error; often learning as much from our mistakes as from our successes. This means that individuals must be afforded the right to learn and grow from experiences, in an atmosphere that is supportive and encouraging. The goal of all services is to assist the person to remain safe, while learning or re-learning needed skills necessary to recover.
- **Mutuality:** In peer-to-peer services there are no hierarchal relationships. Individuals share rather than lead. Mutuality means that people have similar backgrounds and can self-disclose about their experiences in overcoming. The mutual sharing nature of the relationship empowers the individual to overcome any shame or stigma related to the substance use disorder or mental health issue.
- **Non-Hierarchal:** The word hierarchy is defined by Merriam-Webster Dictionary as the classification of a group of people, objects, categories, etc., according to ability or to economic, social, or professional standing; *also*, a graded or ranked series. Essentially, it is a value arrangement of people, objects or categories being represented or perceived as being “above,” “below,” or at the “same” level. Peer-to-Peer services are non-hierarchal which means that the person providing and the person receiving services are “at the same level.” This brings in the “mutuality” of the relationship.
- **Authentic:** Peer support work is described by participants as being authentic when persons providing peer services can use their lived experience, engage in mutually beneficial discussions, and be a role model. However, in the “New World Order” which includes Medicaid reimbursement for peer services, authentic peer services also requires that they must be services defined as being appropriate for Medicaid reimbursement. More importantly, peer services must fall in categories of authentic peer support. However, one of the major challenges that are noted by persons working in peer-to-peer services has been that many

peers talk about being asked to do things that are not in their job description (co-optation). Challenges to authentic peer integration include acceptance of peer services, training, the need for credentialing, and peer self-care.

- **Without Cooptation:** The literature describing implementation of peer services has identified the *cooptation* of peer support staff as a major barrier to the provision of effective peer services. Cooptation is related to role clarity. Certified peers working in clinical settings have reported that they have been pressured or directed to step out of their roles as peer's support providers and take on more traditional professional activities which are case management-based or clinically-oriented. This tendency for role shift can detract from, or conflict with, the intended functions and values of peer services. In addition to clinical roles some peers have stated that the value of what they bring to the agency is often perceived to be lesser than clinical staff, and this can be evidenced through the peer being asked to do other work that is outside of their roles such as asking the participant to comply with treatment or observing urine screenings.
- **Peer support is voluntary:** Recovery is a personal choice. The most basic value of peer support is that people freely choose to give or receive support. Being coerced, forced or pressured is against the nature of genuine peer support. The voluntary nature of peer support makes it easier to build trust and connections with another.
- **Many Pathways to Recovery:** The phrase "there are many pathways to Recovery" is a truism that defines peer services. Peer-to-peer services entail working with people from and being linked to multiple pathways; including but not limited to—SUD treatment, mental health, faith, natural, health, and harm reduction. In addition, the opioid epidemic has been declared a national epidemic the pathway of Medication Assisted Treatment must take a front and center role in the current opioid epidemic.
- **Diversity:** The peer provider must be able to meet people where they are at and this means being able to work with people from all walks of life including faiths, ethnicities, sexual orientations, genders and very importantly today, political persuasions; providing them excellent and compassionate services.

“In the time of a massive nationwide opiate epidemic there can’t be a more important topic than Medication Assisted Peer Recovery Support Services. We have known since the **1997 NIH Consensus Conference that the "Gold Standard" for treating opiate addiction is methadone** in conjunction with appropriate ancillary services. The ancillary services we are talking about is in conjunction with recovery support services. 60,000 people will overdose this year who don't have to. Peer recovery Support Services are an extremely low cost efficient method to combat this disease and because of stigma we are letting thousands die each year. Shame on anyone who lets a child die because they don't support evidence-based science.” – **Walter Ginter**



On Track–Values Signposts to Effective Peer-to-Peer Services

Following are characteristics of good peer services. They are markers that should be discussed with staff along with the preceding values. The program must encourage and support a culture of valuing authentic peer services which is characterized by the following organizational environmental factors:

- **Relatability:** The power of a peer-to-peer relationship particularly one that occurs naturally (one peer relating to another on their own without a program) can be powerful. However, in a natural occurring peer-to-peer relationship, the key issue that makes the relationship so effective is that these individuals **relate** to each other—they see themselves in the other person. The power of this relationship may not be easily duplicated in a professional setting; but as peer services move forward in the program, effective peer services will require employing peers that the program demographic can relate to in terms of similar culture, background and issues.
- **Commitment to recovery, evolution, and inspiring hope:** The program should seek commitment to recovery, evolution and the inspiring of hope through ongoing training and dialogue with each staff member, including clinical and non-clinical staff: to convey a commitment, to the evolving understanding of recovery, and instilling hope. This is a core value of the peer-to-peer relationship.

- **Direct, honest, respectful, communication:** The nature of peer-to-peer communication is defined by honesty, but it must also be respectful even when choices are made by the participant that we may not consider to be in their best interests.
- **Trauma Informed Care (TIC):** Research has documented a high incidence of comorbid Post-Traumatic Stress Disorder (PTSD) and substance use disorders. Providers, in general, and particularly those who provide peer services must adopt a trauma-informed organizational mission and commit resources to support it. This entails implementing an agency-wide strategy for workforce development that is in alignment with the values and principles of TIC and the organization's mission statement. Without a fully trained staff, an organization will not be able to implement the TIC model. However, simply training behavioral health professionals in TIC is not enough. Counselors will not be able to sustain the kind of focus required to adopt and implement a trauma-informed philosophy and services without the ongoing support of administrators and clinical supervisors.
- **Belief in the power of the relationship:** When people have similar backgrounds and life experiences, they can experience a powerful connection in relating to one another. When you apply this to authentic peer services relationships that same connection can occur. Both peers and providers must understand/believe in the power of peer-to-peer relationships to effect better outcomes.
- **Moving toward (not away from):** This means that the peer-to-peer framework includes helping each other move towards what we want, as opposed to away from what we don't want.
- **Creating community:** A *community* is something that is created, it doesn't just happen. It takes specific intent. Too often, people approach community the wrong way. We start with the idea that someone else needs to create it and then we wait to be invited into it. The reality is, that, if we have strong feelings about what needs to happen, we need to be a part of *making it happen* (creating community). One of the best places to start creating community, is to pay attention to the things that you desire or want to see changed in a certain area; or what bothers you; what you are frustrated about or wished existed is a big clue to a specific need, and, is an area where there is opportunity for someone to create the community within the peer services realm.

Note: Much like trauma-informed services, without training of all staff on the peer values and peer services framework, the agency may be disadvantaged in implementing authentic peer services.

"Peer Support Peer-Driven services are people-friendly and cost-effective. Peer-services are essential for the future of sustaining long-term recovery." — **Andre Johnson**



Preparation

Organizational Readiness Assessment

Once your organization understands peer support values, it then needs to determine if those services work within your organization. You may want to take an organizational readiness assessment for peer services.²³ There are many types of peer services in the SUD and mental health fields and not every service will be appropriate for every organization. Each organization will need to look at and answer five very important questions:

1. Do peer services fit the mission of this agency—are they mission congruent?
 2. Do we have or anticipate having program participants that could benefit from peer services?
 3. Do the participants in our programs want peer services?
 4. Do we have the skills and or resources to implement peer services, and, if not, can we acquire them?
 5. Is it fiscally possible and responsible?
1. **Mission Congruent:** Each organization has a vision that drives its decision-making process and how it interacts with other organizations, including funders and payers. This vision is expressed in the organization mission statement. To determine if a new service such as peer-to-peer services is congruent, an organization needs to look at that mission statement and then examine the methods they use to project its vision to entities outside the organization such as partner organizations, regulatory bodies, payers and consumers. For example, if your organization believes, they “provide scalable solutions to transform lives” (Services for the Underserved) that “there is good in everyone” (Samaritan Day Top Village), or that “people are experts in their own lives” (Community Access), the organization must examine how it translates that belief into policies, staffing and services. An organization's services are part of its internal processes. When examining congruency, the organization should look at their services and evaluate, not only the quality, but also the short and long-term outcomes, and then, work backwards through the service delivery process and quality control processes to find ways to improve output and outcomes. The organization examines how adding peer services achieves quality measurement objectives such as sustainable recovery, community integration, reduced hospitalizations and lower rates of recidivism that will inform value based payment, quality improvement and other initiatives requiring outcome metrics.
 2. **Benefit to program participants:** You may want to review the Pre-Contemplation stage of change with the knowledge of your program. You will need to identify whether you serve a population that will benefit from and want peer-to-peer services. It is critical that organizations do not assume they know what is best for the people they serve. Educating participants about peers and the services they provide will inform the decision-making process. Other areas to examine are:
 1. Would they be comfortable having peers that were once participants at the same organization?
 2. How would they feel if the peer received services at the same organization?
 3. Do they believe they would benefit from peer services?

²³ <https://www.hivtrainingny.org/FAQDocs/ORGANIZATIONALASSESSMENT11315.pdf>

3. **Program Skills/Resources:** Determining the skills and resources that your program must integrate to facilitate peer services includes: knowing your program's stage of change; reviewing staff knowledge and experience with peer services and determining how much training your program staff will need and how your program will acquire the peer(s) that your program will employ. Will you start with peer interns? Do you want to have one of the interns/volunteers pursue provisional certification, or utilize a peer with current provisional certification? Will you identify a person currently in treatment who you want to have work towards certification? Will you employ a person who is currently certified? (Source: New York Certification Board.²⁴) Do you already have certified peers working in your program that are a good match for the population you serve? Please note some of these options may not work well for your program. For instance, it is generally not a good idea to use a person who has recently completed treatment within your program or current staff to provide peer-to-peer services in your program.
4. **Break-Even Point:** Is it fiscally viable and responsible to implement peer services within your organization? There is no getting around the fact that there is a cost to implementing peer services, as it is with any new services. NYS OASAS Field Office staff developed the following break-even budget as a guide for you to review the cost of hiring a peer and the level of services per week that will be required to support the peer. Please note that while these costs are significant for any program that is just meeting the break-even point, this may also bring significant advantages in outcomes, retention and census that are beyond the fiscal advantages. As fiscal staff, knows, the break-even point is the point in time (or in number of units sold) when forecasted revenue exactly equals the estimated total costs, where loss ends and profit begins to accumulate. This is the point at which a business, product, or project becomes financially viable.²⁵

Understanding the Fiscal Reality of Integrating a Certified Peer Services

Once you understand peer services, this information should be shared and discussed with staff. Simultaneously, you may want to start looking at the fiscal feasibility of adding peer services and share this with your fiscal staff. To do this, it is important for organizations to look at all the implications of providing a new service. For example, what will the impact be on the overall agency of creating a new position or hiring a new staff person? This includes the impact on the following: fiscal, human resources, facility, technical requirements, staffing to client ratios, and client outcomes. Ultimately, organizations will need to determine the cost benefit based on both participant outcomes, such as, reduced hospitalizations and increased duration of recovery and the actual agency cost of hiring peer staff. See preparation break-even budgeting tools at the end of this section.

Billable Services

At the current time, there are two main billable sources for Medicaid billable peer-to-peer services within NYS OASAS: 1) Outpatient programs 822 Medicaid billing and 2) Home- and Community-Based Services (HCBS).

Peers working in Outpatient 822 programs can provide Medicaid billable *Peer Support Services*. Per Part 822 regulations, "Peer support service" is a face-to-face service provided by a Peer Advocate to a current patient. Peer supports are services for connecting patients to community-based recovery supports consistent with the treatment/recovery plan." Peer support services²⁶ include:

²⁴ <http://www.asapnys.org/ny-certification-board>

²⁵ https://www.google.com/#safe=active&q=break+even+point+definition&*&spf=433

²⁶ <https://www.oasas.ny.gov/ManCare/documents/PeerSupportServicesGuidanceFINALDraft2017.pdf>

1. Pre-admission engagement services
2. Developing recovery plans
3. Raising awareness of existing social and other support services
4. Modeling coping skills
5. Assisting with applying for benefits
6. Accompanying clients to medical appointments
7. Providing non-clinical crisis support, especially after periods of hospitalization or incarceration
8. Accompanying clients to court appearances and other appointments
9. Working with participants to identify strengths
10. Linking participants to formal recovery supports
11. Educating program participants about various modes of recovery
12. Travel training—to use public transportation independently

Under revised 822 regulations, peer support in Outpatient 822 settings is defined as: *Peer support services are for the purpose of **outreach for engaging** an individual to consider entering treatment, **reinforcing current patients' engagement in treatment**, and **connecting patients** to community-based recovery supports consistent with treatment/recovery and discharge plans.*

In addition, 822 Outpatient services may provide **Continuing Care services**. The following are examples of how peer support services can be utilized in 822 Outpatient Services.

1. Pre-Admission Engagement Services

- Outreach for engaging an individual to consider entering treatment — Peers will be able to engage with individuals in the 822 Outpatient settings, in the community, in a targeted areas or other system settings (i.e., criminal justice setting, human resources office, drug court child welfare offices, or other settings, for the purposes of connecting the individuals to treatment or other community-based recovery supports) before and apart from admission to treatment. This engagement does not need to result in an admission, but requires documentation of a service rendered in a way that meets audit standards and demonstrates medical necessity. The note must document evidence of face-to-face contact with the individual, information about the patient's demographics, Medicaid card information, and what information that you provided on community recovery supports. While this is not a clinical assessment, the provider may want to give the Peer a form with questions to ensure meeting audit standards and demonstrating medical necessity. In this case, medical necessity means the person would likely benefit from admission to treatment.

2. Reinforcing current patients' engagement in treatment *and connecting patients to community based recovery supports consistent with treatment/recovery and discharge plans*:

See numbers 2-12 in previous description of peer services for a list of peer support services to support engagement in treatment and connect participants to community supports.²⁷ This list may not be inclusive of all peer support services.

3. Continuing Care²⁸—To allow for continuous connection to treatment over time, OASAS has included continuing care in the new PART 822 regulations. This will allow programs to discharge an individual from an outpatient episode of active care in an outpatient setting (outpatient clinic or Opioid Treatment Program) into continuing care. The person will be able to access counseling, peer services, medication assisted treatment and recovery supports following treatment for an indefinite period of time. For some, this may be for only a few months as they transition to recovery supports in the community, for others it may be for many years. The individual counselor must identify the goals of continuing care and expected frequency of visits. Individuals may be seen for counseling, medication and/or peer services within the same month.

²⁷ <https://www.oasas.ny.gov/ManCare/documents/PeerSupportServicesGuidanceFINALDraft2017.pdf>

²⁸ <http://www.oasas.ny.gov/ManCare/documents/ContinuingCareGuidance.pdf>

Home- and Community-Based Services

Home and Community-Based Services (HCBS) were developed collaboratively by New York State's Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), and the Department of Health (DOH) and are a part of the State's Health and Recovery Plan (HARP) for individuals with serious mental health and/or substance use disorders.

Agencies that have successfully completed the Adult Behavioral Health Home- and Community-Based Services (BH HCBS) application and designation process are given a BH HCBS provider designation²⁹ status. This provider designation status identifies that your agency has attested to provide BH HCBS within the agency's scope of practice and consistent with the criteria articulated in the BH HCBS manual.³⁰ Your agency will only be designated to provide the BH HCBS that are included within your application and approved by the State.

The HCBS services that can be provided by unlicensed staff including Certified Peers are:

1. Psychosocial Rehabilitation
2. Habilitation
3. Family Support and Training
4. Short Term Crisis Respite
5. Intensive Crisis Respite
6. Empowerment Services

For individuals that are eligible for HCBS services, participating in treatment is not a condition of receiving those services.

Empowerment Services - Peer Support Definition

Using Empowerment services as one example, HCBS Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (i.e., hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from SUD and mental health issues.

Activities included in HCBS services must be intended to achieve the identified goals or objectives as set forth in the participant's individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant, and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery.

²⁹ <https://www.omh.ny.gov/omhweb/bho/provider-designation.html>

³⁰ <https://www.omh.ny.gov/omhweb/bho/hcbs-manual.html>

The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery. There are six categories of peer-support components:

1. Advocacy
2. Outreach and Engagement
3. Self-help Tools
4. Recovery Supports
5. Transitional Supports
6. Pre-Crisis Supports

Note: For a full description of these service components, see page 19 of the Home- and Community-Based Services Manual at www.omh.ny.gov/omhweb/bho/hcbs-manual.html.

Recovery Plan, 822 and HCBS Note sample tools follow in this section.

Cost Benefit Implications for Client Outcomes

Before laying out the various components of a program that incorporates peer services, it is important to note that there is more than one way to create an effective and sustainable program. A program in its first year may look quite different from a program two years later, but both may be equally effective. At this point, you are ready to go on to the very concrete steps that must be taken in Action, Maintenance and Wellness. It is in these stages that leadership create job descriptions and staffing patterns that articulate the difference between those employees whose time is billable and those who are not.

Organizational processes need to delineate tasks in such a way that billable staff are generating income for the preponderance of the time that they are working.

Note: Before the actual hiring process, all levels of agency staff should have training on the integration of peer-to-peer services. This training must focus on the values of peer services, and the role of peer (what peers can and cannot do). The peer's role should be reflected in the mission statement for peer services. There should also be a formalized training plan in place for peers. It is also crucial to have executive support for the integration of peer services. There must be a strong champion for peer services within the agency.

Preparing to Hire a Certified Peer Recovery Advocate—Job Description

One of the most important factors in determining whether an employee hired as a peer will be successful is the clarity of his or her job description. Below is a list of important questions to consider when preparing Peer job descriptions:

What are the organization's goals in hiring peer service providers?

Organizations should not hire peers simply as a less expensive option to fill staff vacancies or to do tasks that other staff do not want to do (i.e., escorting clients). An appropriate reason for employing peers is to assist individuals to attain or maintain recovery through accessing recovery supports and services.

What are the specific job duties of the peer provider?

The answer to this question will vary depending on the needs of the organization and on the skills of the peer candidate. Peers can perform a wide variety of job functions, but organizations should not

assume that one peer can perform every job function. Thought should be given to ensuring that eligibility criteria are appropriate for the position. For example, what education level and experience does the position require? Should there be a specific length of time in which the candidate has been free of hospitalizations or substance use? For example, some organizations require six or twelve months or even three years without a mental health hospitalization or active substance use.

Recruitment

Recruitment of Peers can be challenging and unfamiliar for Human Resources' staff. It is an unlawful, discriminatory, human rights violation for an employer to make any inquiry about any arrest or criminal accusation of an individual which is not currently pending against that individual, or which has been resolved in favor of that individual, resolved by a youthful offender adjudication, or resulted in a sealed conviction³¹. However, it is legal to consider experience with the receipt of behavioral health services as a job qualification for peers. Nonetheless, it may be awkward to ask about a behavioral health history during the hiring process. Therefore, including language related to such experiences is critical in the posted job description, as is full disclosure of what is expected in the job interview. For example, the interviewer might say, "As one who has availed themselves of behavioral services, the Peer Recovery Advocate will share their own experiences and what skills, strengths, supports, and resources they use. As much as possible, the Peer Recovery Advocate will share his/her own recovery stories and will demonstrate how they have directed their own recovery processes." (Matthew Chinman, 2013) This language conveys that experience with behavioral health is among the many attributes that are positively valued.

Recruitment for peer positions may be handled in a variety of ways. One possibility is to post a job opening as the organization would for any other position. Refer to the preparation job advertisement tool at the end of this section. Another possibility is for staff to identify individuals who might be peers who are good at motivating and helping other people find strengths that they were not aware of. For those organizations that have determined peer staff and services would be mission congruent and fiscally viable, but find that staff and persons being served within the program have concerns about using current or recent participants as peers, an excellent source to identify peers outside the organization is to contact either of the New York State peer certification boards. The Certification Board keeps a list of persons who have received their certification. You can list a position with them, and they will send out an e-mail to all likely candidates or you can ask for a list of individuals who are certified in a certain area. Following is link to the New York Certification Board that handles Peer Recovery Advocates certification in New York State: www.asapnys.org/ny-certification-board/.

Policies and Procedures

If the organization decides to hire participants from within their own organization, it will be important for them to have established policies in place that answer questions such as:

What will be the policy for fraternization with clients?

Dual-relationship circumstances, i.e., peers' preexisting participant relationships and new staff relationships, are common and are sometimes challenging. There are no standard policies. However, practices have ranged from requiring the peer to sever all relationships with participants in the organization to allowing these relationships, but requiring that they not be romantic or financial to minimize the possibility of exploitation. The key to addressing issues of fraternization is to have clear, well-communicated policies that are consistent with ethical standards, reliably enforced, and locally developed with input from multiple stakeholders including peers. (Philadelphia Department of Behavioral Health and Intellectual Disability Services, 2014)

When developing policies and procedures associated with peer services the key is to address roles responsibilities and processes as you would with any new service you added to the organizations portfolio. Do not create policies specific to "peers" and in effect create a second-class employee with

³¹ [Human Rights Law §296\(16\)](#)

peer input. While research shows, there may be some challenges specific to peer services this is no different than with any other significant change an organization implements. Some of the challenges to be addressed include:

- **Role confusion** — Lack of clarity about peer’s duties.
- **Staff training needs** — The agency will need to train its entire staff on the integration of peer services.
- **Staff resistance** — The provider must ensure that the peer:
 - does not receive less supervision and support and
 - is not excluded from certain meetings.
- **Unequal treatment** — The peer is treated differently than other professional staff when the peer provider is:
 - encouraged to volunteer for peer support roles rather than have a paid position,
 - the agency does not develop a viable career path within the agency or peer leadership roles,
 - the peer does not have access to medical records,
 - the peer is relegated to grunt work, and/or the
 - agency supervisory staff question reasonable accommodations and scrutinize sick leave differently from other staff.

While raised as issues to be addressed when implementing peer services, addressing these concerns are simply best practice for any new role introduced into an organization. On the other hand, knowing which peer will be a good fit for your organization is critical to successfully implementing peer services. The assumption made by many organizations is that any certified peer will be able to fill the position your organization has, and nothing could be further from the truth. As is true with any other position the organization is looking to fill, credentials are not enough, experience including specific life experiences, skills, work style and personality will all contribute to how well an individual will fit into and work with the existing team.

Evaluating the existing team structure and how well it functions as well as the job description is very important and recommended when introducing a new structure to the organization. It will help your organization identify the traits you are seeking in an individual and/or in any new staff member including a peer. There are several quantitative tools that have been developed for the evaluation of inter-professional teamwork. While such tools have their limitations, they may be useful as part of a mixed method, evaluation which combines data generated from their use with qualitative sources for programs that want to strategically add peer staff to their existing staffing structure.

Peer Certification

It is important for providers to understand the certification process before they start the hiring process. Traditionally persons providing peer-to-peer services did not require certification. Training and skill development was left up to individual organizations providing services. Many individuals also sought training through specialty advocacy programs (like national self-help technical assistance centers). Funding was primarily awarded by grants that were under the control of State mental health authorities. New funding sources such as Medicaid require standardization of training and experience. Individuals who work in OASAS Part 822 Outpatient and Office of Mental Health service programs must be certified. Following are the requirements for certification in both systems:

Recovery Coaches

It is important for providers to also understand the role of the Recovery Coach. Recovery Coaching is a form of strength-based supports for persons in or seeking recovery from alcohol and other drugs, and other addictions. Like life and business coaching, Recovery Coaching (also known as peer mentoring) is a type of partnership where the person in or seeking recovery self directs his/her recovery while the coach provides expertise in supporting successful change. Recovery Coaching focuses on achieving any goals important to the individual. The coach asks questions and offers

suggestions to help the person in recovery begin to take the lead in addressing his/her recovery needs. Recovery Coaching focuses on honoring values and making principle-based decisions, creating a clear plan of action, and using current strengths to reach future goals. The coach serves as an accountability partner to help the person sustain his/her recovery. The Recovery Coach helps the person access recovery, as well as access systems needed to support recovery such as benefits, health care, etc. Recovery Coaches also:

- develop the recovery plan;
- help to initiate and sustain an individual/family in their recovery from substance use or addiction;
- promote recovery by removing barriers and obstacles to recovery;
- serve as a personal guide and mentor for people seeking, or already in recovery;
- help a client find resources for harm reduction, detox, treatment, family support and education, local or online support groups; or help a client create a change plan to recover on their own; and
- help individuals find ways to stop using (abstinence), or reduce harm associated with addictive behaviors.

Recovery Coaches work with individuals beyond recovery initiation through stabilization and into recovery maintenance. They function as a guide to help with decision making and support steps toward recovery. A recovery coach is not the same as a CRPA and neither they, nor an OASAS program with which they may be associated, may bill for CRPA services, including peer support services, as defined herein and by 14 NYCRR Part 822. CARC certification alone does not allow an individual to charge or bill third party reimbursement for services as a private practitioner. A trained and qualified recovery coach may only charge a fee for services if they also maintain another license or credential under which they have the authority to provide and charge for treatment services. Furthermore, a recovery coach shall not receive, nor be offered, any fee for the referral of a patient to treatment services from the program to which they refer.

Preparation Tool: Peer Certification Criteria

Requirements	Substance Use System	Mental Health System
Education	Minimum of High School Diploma/GED	High School Diploma/GED
Content Specific Training	46 hours total as follows: -Advocacy: 10 hours -Mentoring/Education: 10 hours -Recovery/Wellness Support: 10 hours -Ethical Responsibility: 16 hours	Complete all 12 Core Courses from the Academy of Peer Services www.academyofpeerservices.org
Work Experience	500 volunteer or paid work experience in field	A minimum of 2,000 hours either in a paid or volunteer experience doing activities
Supervision Hours	25 on the Job Supervision Hours	No supervision required
Other	2 Letters of Recommendation (1 personal and 1 professional) Background Check	Mental Health Diagnosis 3 reference letters

Preparation Tool: Certified Peer Advocate Break-Even Budget

Rate per unit/hour = \$52	
Full-time Work Week = 35 hours (1 FTE)	
Salary at \$15/hour = \$525/week = \$27,300.00	
Yearly Salary	\$ 27,300.00
FICA and Fringe @ 30%	8,190.00
Total	<u>\$ 35,490.00</u>
OTPS	500.00*
Agency Admin. @ 15%	<u>*5,399.00</u>
Total Budget	<u>\$ 41,389.00</u>

*These are flexible costs.

PROJECTED INCOME (based on 42 work weeks)

$\$41,389/\$52 = 795$ hours for break even

$795 \text{ hours}/42 \text{ weeks} = 19$ hours per week of services = 4 hours/day of needed services

Note: See next page proposed 50% increase to current rate of \$52/hour for Part 822 Outpatient services Certified Peer Advocates. The salaries paid to peers are for example purposes only and are intended to assist with understanding the breakeven point calculation.

Preparation Tool: Proposed Rate

Certified Peer Advocate Break-Even Budget

Rate per unit/hour = \$78	
Full time work week= 35 hours (1 FTE)	
Salary at \$20/hour = \$700/week = \$ 36,400	
Yearly Salary	\$ 36,400.00
FICA and Fringe @ 30%	10,920.00
Total	\$ 47,320.00
OTPS	500.00*
Agency Admin. @ 15%	* 7,173.00
Total Budget	\$ 54,993.00

*These are flexible costs

PROJECTED INCOME (based on 42 work weeks)

$\$54,993/\$78 = 705$ hours for break even

$705 \text{ hours}/42 \text{ weeks} = 17$ hours per week of services = 3.5 hours/day of needed services

Preparation Tools: Team Evaluation Before Hiring Peer

Tools to Evaluate Interprofessional Teamwork

Team Climate Inventory: This tool was developed by Anderson and West (1994, 1998) as a set of four separate but interrelated scales which aim to measure different aspects of collaborative work. First, team objectives, a 13-item scale focused on clarity of team objectives and member's commitment to team objectives. Second, team participation, a 12-item scale focused on team members' attitudes to cohesion and participation. Third, quality, a seven-item scale focused on the extent to which team members promote quality in their teamwork processes. Fourth, support for innovation, an eight-item scale focused on the amount of effort and resources given for implementing innovation.

Aston Team Performance Inventory: This tool was developed to examine the factors influencing team effectiveness in three areas by assessing the main inputs or contextual factors that influence team functioning; team and leadership processes; and the team's overall performance. The Aston Team Performance Inventory (ATPI) can be administered electronically or manually. The tool, it is claimed, is suitable for a range of teams. For more information, see: <https://nexusipe.org/informing/resource-center/aston-team-performance-inventory>.

Team Effectiveness Questionnaire: Developed by Poulton and West (1993, 1994), this tool has 25 items and aims to measure how 'effective' a team is in relation to four dimensions: teamwork (communication strategies, collaborative working, valuing others' roles); organizational efficiency (clear procedures, innovative practice, keeping within budgets); health care practices (staff development, research-based practice, equal opportunities) and patient-centered care (provision of information, clinical competence).

Extraprofessional Collaboration Scale: This 13-item scale aims to measure perceptions of extraprofessional collaboration between nurses, physicians and other health professionals. The items were written from the perspective of respondent groups to name other professionals as targets of the item concepts (i.e., 'nurses have a good understanding with physicians about our respective responsibilities'). Items were adapted from the Nurses' Opinion Questionnaire (Adams et al., 1995). The scale's items were written in a round-robin format to specify 'target' groups and 'rater' groups. The three underlying subscales address communication with other groups, accommodation and isolation/autonomy (Kasack et al., 2010).

System for Multiple Level Observation of Groups: Developed by Bales and Cohen (1979), this tool is a 26-item rating scale that aims to measure individuals' behaviors based on three dimensions: prominence (dominance and assertiveness); sociability (warmth, friendliness) and task orientation (rationality towards tasks and task-focus).

Interaction Process Analysis: The Interaction Process Analysis tool was developed by Bales (1976) to categorize and understand the nature of interaction within groups or teams. **Bales' Interaction Process Analysis (IPA) is a classic in the study of small group interaction. His research investigates measures of leadership in small, face-to-face groups.**³²

³² <https://www.csudh.edu/dearhabermas/bales01.htm>

The observation of interaction is based on assigning behavior to several categories including agreeing/disagreeing, giving/asking for suggestions and giving/asking for opinions. In recording interaction between group members within these categories, this tool aims to understand the issues and processes around communication, control and decision-making. (National Center for Interprofessional practice, 2010). Robert Freed Bales was a Professor of Social Relations and Director of the Laboratory of Social Relations at the University of Harvard on a very practical level. Bales was known for being “trusted and admired by his colleagues.” They and his students regarded him with deep affection. Bales was one of few faculty members in Social Relations who had moral authority derived from his colleagues’ recognition that he placed the welfare of the department above personal motives. ³³

³³ <http://infed.org/mobi/robert-freed-bales-group-observation-and-interaction-processes/>

Preparation Tool: Job Description

Sample Peer Job Description

Job Qualifications:

- Lived experience in mental health, substance use, and criminal justice
- Willingness to disclose lived experiences
- Certification as a Recovery Peer Advocate (substance use) or Peer Specialist (mental health)
- Computer skills – MS Word proficiency
- Experience doing documentation in a Foothold EHR preferred
- Able to navigate New York City public transportation system
- Knowledge of benefits/entitlements for people with disabilities
- Clear written communication skills
- Ability to speak Spanish a plus

Summary Job Description:

- Participate as a member of the clinical team providing services to people with behavioral health challenges and linking them to needed services/resources. Peers use their shared personal lived experience to promote clients' recovery, offering support, advocacy, and skill development opportunities. Majority of participant contacts take place face-to-face in the community. Documentation of services provided is a component of this work. Peers must be certified.
- Report to: Director, Drop in Support Center and Director, HCBS Department
- Supervisory Responsibilities: None

Detailed Responsibilities:

- Provide recovery support to clients by sharing life experiences
- Follow HCBS peer support service delivery protocols
- Document in Electronic Health Records (EHR) services provided to clients
- Attend supervision with supervisor once a week
- Accompany clients to appointments, as needed
- Support program participants in pre-crisis or crisis situations
- Teach participants recovery skills, based on shared life experiences
- Help participants transition from inpatient to community settings, as needed
- Share information with participants about benefits, entitlements, and other supports
- Provide outreach to help participants connect with desired services
- Link participants with needed community resources and treatment services

Note: Majority of support provided face-to-face in community settings.

Preparation Tool: Advertisement for Peer Recovery Advocate

Certified Peer Recovery Advocate

Salary: "Insert Salary"

The ABC organization, a leader in the behavioral health field for over 35 years, is looking for a Certified Peer Recovery Advocate (CRPA) to become a team member in its outpatient 822 program. The successful applicant will be a self-starter able to use their lived experience (within the Outpatient clinic, and in the community) working with persons in or seeking recovery from substance use issues. The CRPA will work as a fully integrated team member providing peer recovery support to individuals in the outpatient clinic setting and in the community.

Summary of Job Responsibilities:

- Assist peer participants in the development of a personal self-directed recovery plan
- Work with participants to identify strengths
- Link participants to formal recovery supports
- Assist with the review and discussion of the peer's recovery plan
- Provide peer participants with information on existing community supports and services
- Model coping skills
- Assist peer participant with applying for benefits
- Accompany peer participant to medical appointments
- Provide non-clinical crisis support, especially after periods of hospitalization or incarceration
- Accompany peer participants to court appearances and other appointments
- Educate program participants about various pathways to recovery
- Provide travel training to use public transportation independently
- Identify and support linkages to community resources that support the peer participant's goals and interests

Job Requirements:

- High School Diploma/GED and 2 years work or volunteer experience in a recovery-oriented setting
- NYS Certified Recovery Peer Advocate (CRPA)
- At least 1-year volunteer or paid experience working as a Recovery Coach or Provisional CRPA
- Knowledge of substance use disorder recovery process
- Computer competent
- Culturally competent

The following are considered a plus:

- Prior experience working as a Certified Recovery Peer Advocate
- Experience working with persons with co-occurring mental health issues
- Experience with data based systems such as the AWARDS system
- Familiarity with Home and Community Based Services (HCBS)
- Experience in documenting Wellness/Recovery Plans

“We live in a transactional world, where goods and services are distributed in measurable quantities with a designated price. But we now know that this doesn't work in health care. If we want to help people get and stay healthy, we need relationships with them. Peer support providers are invaluable for rooting care in relationships that will sustain people in recovery.” — **Luke Bergmann, PH.D**



Action

Hiring:

The hiring process is that aspect of the implementation process that most agency leaders find the most anxiety provoking or confusing. One of the areas of greatest confusion, has been related to issues that generally fall within legal considerations related to hiring people with a history of a disability.

Personnel and Legal Considerations:

In this section, we outline common personnel and legal issues that may arise as behavioral health agencies strive to maximize the employment of persons in recovery in multiple roles and across all levels of the service system. These roles include employment in positions tied directly to individuals' own experiences of behavioral health conditions and recovery—peer positions. While we have tried to be comprehensive, this discussion is not intended to be an exhaustive review; nor is it to substitute for situation-specific counsel from human resource and legal professionals.

General Considerations:

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 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.

The employment provisions of the Americans with Disabilities Act (ADA, Title I) of 1990 prohibited discrimination against persons with disabilities regarding 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 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 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.

Pre-Hire Issues for Consideration:

How do we word and handle advertisements/postings as we do outreach to hire persons in recovery?

For all employment positions, the EEOC advises employers to include a non-discrimination clause in job postings, i.e., “We are an Equal Employment Opportunity Employer. We do not discriminate based on race, religion, color, sex, age, national origin, or disability.” For specialized positions tied directly to individuals' personal experiences of behavioral health conditions and recovery “peer-based” positions)

it is allowable to refer to psychiatric disability within the job description/posting if having had this life experience is related to an “essential function” of the job. For example, 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 providers] will share their own experiences and what skills, strengths, supports, and resources they use. As much as possible, [peer providers] will share their own recovery stories and will demonstrate how they have directed their own recovery processes.”

Are there certain types of questions we can/cannot ask during the interview and hiring process?

Title I of the ADA 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 a disability. The types of questions which are prohibited differ across the following three phases: pre-job offer, post-job offer, and during employment.

At the pre-offer stage, an employer cannot ask disability-related questions: either directly or indirectly. For example, it is prohibited to ask the following: “Do you have any physical or mental impairment that would keep you from performing the job you seek?” or “What medications are you currently taking?” or “How many days were you out sick last year?” or “When were you last in the hospital or in a detox program?” These questions, either directly or indirectly, require an individual to disclose personal medical or disability-related information, and they are prohibited to ensure that an applicant’s possible disability is not considered before employers objectively evaluate the applicant’s qualifications. In addition, these questions are considered potentially discriminatory because they do not focus on what should be the sole topic during the interviewing phase, i.e., whether the applicant can perform the essential functions of the job, with or without reasonable accommodations. In contrast, 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/examinations are: a) job related and consistent for business necessity, and b) required for all other entering employees in that same job category.

Post-hire Issues for Consideration:

Will a person in recovery be entitled to accommodations on the job due to his or her disability?

Do not assume that a person in recovery will require any modifications on the job. It can be presumptuous and offensive to an employee to assume he or she will need accommodations or to automatically “exempt” him or her from performance expectations that are applied to others on the job simply because he or she has had a behavioral health condition. If, and when, performance issues do arise, employers should also not assume these issues are necessarily related to the person’s behavioral health condition. However, if an employee does disclose 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 enjoy 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.”

During the hiring process, individuals considering work as a peer 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. While it is not incumbent on the hiring committee to raise these issues, it is important that there are either knowledgeable people on staff or people to whom you can refer the potential or new employee who can provide information and perhaps guidance on navigating these systems. With respect to disability-based income (i.e., Social Security Disability Insurance—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. **It is important to direct the potential peer staff to the New York State Education Department (ACCES-VR)**³⁴

Onboarding your Peer:

Once hired, what training will new peer staff receive either as part of new employee orientation and/or specific to their new role?

It is good to have this information available at the time of interviewing candidates. Discussing training needs may give you a sense of the person's previous experiences, sense of confidence, and self-assessment of training needs as well as provide more clarity about role expectations. Depending on the job, some peer applicants will have had extensive pre-service training, including certification, while others may have had very little, if any at all. Discussing what aspects of the job the applicant is most comfortable with and where he or she might anticipate needing the most training or support can be a very useful process for both parties. (Philadelphia Department of Behavioral Health and Intellectual Disability Services, 2014)

Training:

What will the peers' ongoing training consist of?

There are different ideas about what peer training should look like, especially in terms of how much training is required before the job starts, and where training should be provided. Some of the key content that might be covered in training falls into two main areas:

Training on relevant topics:

- stages in the recovery process;
- the impact of diagnosis on one's self-image;
- mental illnesses - you and your family;
- substance use disorder - you and your family;
- self-help and mutual support groups;
- boundaries - how to maintain appropriate "distance" from clients;
 - e.g., not engaging in financial or sexual relationships (See Action Tools at the end of this section.);
 - or an in-depth look at how to draw upon the collective experience of organizations that are providing peer-based recovery support services to identify ethical issues arising within this service arena, and to offer guidance on how these issues can best be handled see the reference below;³⁵
- dual relationships (how to avoid or, if unavoidable, how to navigate having multiple relationships with the same persons;
 - e.g., being both a provider and a friend; being both colleague and service recipient
- confidentiality;
- cultural competency (See Action Tools at the end of this section.); and
- ethics.

³⁴ <http://www.acces.nysed.gov/vr/21000-serving-individuals-who-are-ssdissi-participants-policy#verification>

³⁵ White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits R. & Donohue, B. (2007). Ethical Guidelines for the Delivery of Peer-based Recovery Support Services. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services

Training on relevant skills and knowledge for the job and the setting may include:

- Using one's recovery story;
- the role of peer support in the recovery process;
- advocacy for recovery environments;
- creating relationships that promote recovery;
- beliefs and values that promote and support recovery;
- effective listening and asking questions;
- using dissatisfaction as an avenue for change;
- combating negative self-talk;
- conducting problem-solving;
- the role of spirituality in recovery;
- navigating power, conflict, and integrity in the workplace;
- developing and pursuing recovery goals;
- the basics of medical record documentation; and
- crisis procedures.

Also, most agree that training should be tailored, to whatever extent possible, to the strengths of the individual employee or potential employee; delivered on a regular basis, not just at the beginning of a new hire or new position; and provided at least in part by veteran peers. Finally, it is very important for the rest of the staff (in addition to the Peer) to receive some training on the Peer's role before the Peer is integrated into the program and after the Peer is hired.

Progress Notes:

One of the skills organizations are most concerned with is the ability to document a rendered service in a way that meets audit standards and demonstrates medical necessity. Progress Notes are required to document evidence of face-to-face contact with the participant, information about the patient and/or contact with someone regarding the participant. They are also used in conjunction with the Treatment Plan to assess progress made in completing treatment plan goals and to modify treatment plan goals, if necessary.

To ensure that quality care is being provided, it is essential that an entry be made in the patient's file/chart/record whether on paper or in an electronic data base, during and/or after every session with the participant. Utilizing acronyms to remember the components of a note can be especially helpful for Peers. Some examples are:

GIRPPS: *Goal* you are working on, ***Intervention*** that was provided, ***Response*** to intervention, ***Progress*** since last visit, ***Plans*** until next visit, and ***Signature*** with credentials. There are many acronyms designed to help individuals remember what is required in a note for it to support the billing. **Many providers are used to utilizing SOAP [Subjective, Objective, Assessment, and Plan] or DA (R)P [Data, Assessment, Response and Plan] notes but it is important to remember that those acronyms were developed for physical health care environments. In both Mental Health and Substance Use Disorder the note content is better suited to GIRPPS.**

Peer Services on a Treatment Plan:

When completing a treatment plan that includes peer services, all the basic requirements remain in effect; all diagnosis, individual strengths and problem areas, life areas to be addressed as well as community referrals and resources. Peer services are no different than any other service. You must have:³⁶

1. **Goal(s)** with anticipated date of completion;
2. **Objective(s)** with anticipated date of completion;
3. **Intervention** with duration and frequency;
4. **Provider(s);**
5. **Method(s); and**
6. **Location.**

³⁶ <http://www.multiculturalmentalhealth.ca/clinical-tools/cultural-formulation/>

Action Tool: Sample Interview Questions

*The Interview:

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

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

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

1. Can you tell me some ways that you might use your personal lived experience to support the people you'd be working with? *(Answer should include ideas around "inspiring hope," and around connecting with people from the place of shared experience AND the tools or strategies that the person used to move to a better place.)*
2. What role has peer support had in your own recovery? *(If the person is not familiar with or has not utilized peer support, they are probably not a good candidate.)*
3. This job requires a willingness to share some pieces of your personal story when it makes sense to do so during your work. When could you see sharing your story as a part of your work here? *(Answer may include ideas around 1:1 interaction, at staff meetings or trainings when acting a change agent, etc.)*
4. *Do you have any life experiences that would make you valuable to this program?*
5. *What have you learned through your own use of services that you think would be useful to your work here?*

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

1. How would you define the 'peer' role and how would you describe its key role or tasks? *(Should include mutuality, sharing mutual experience, non-expert role, supporting people to become self-determining; inspire hope, being a change agent, being an advocate, etc. Should NOT be about "making people better," "counseling people" etc.*
2. Part of the role of a peer support worker is to model recovery by sharing some of your own personal experiences. Would you be comfortable doing so?
3. What do you know about the concept of "recovery?" What is your personal knowledge of this and how did you come to this understanding? *(Answer should*

include SUD or mental health-related recovery or healing, not just 12-step recovery.)

4. If you were working with someone who has become resigned to the idea that his or her life will always be limited because of a SUD or psychiatric diagnosis or other challenges, how would you try to support that person? *(The answer should include sharing personal experiences, mutual feelings and tools and NOT telling the person that, of course, it will get better or giving them advice such as, "Well, if you would do... you would have a better chance...")*
5. In many ways, the peer position is a pioneering role. What skills will you bring to the job that will allow you to advocate for people while being in partnership with other staff members? *(The answer could include using a personal story to demonstrate the experience from the perspective of using services. It could also include something about respectful communication to everyone. An excellent response would include something about negotiating power and conflict.)*
6. Peers are often considered to be "change agents" within organizations. How will your experiences help you to be a change agent and how would you see this happening? *(Anything about being able to share experiences with staff, to give them more understanding of the experience from the perspective of someone who's 'been there'; sharing alternative approaches from the self-help community that augments the work of clinicians Recovery Plan, etc. If this notion is a shock to the applicant, it's probably not a good match. They very well may see the role as a mini-clinician and will detract from the value of the role.)*
7. Some staff here may be apprehensive about or unsupportive of peer support. How would you deal with this?
8. If you were in a situation where you were called to help deescalate a situation, how would you respond in that situation?

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

1. This position will require you to work in various settings like inpatient, emergency room, outpatient treatment, residential, etc. How will your personal lived experience support your work in this/these settings? *(The answer should include peer strategies, even if the person's own experience didn't include the particular setting. Conversely if someone says that their experience was very painful and they can't think of any strategies because they don't believe in that kind of treatment, or if they say anything to indicate that they would be uncomfortable in the setting, then it would probably be a bad match.*
2. While working here you may be a part of some situations that disturb you or make you uncomfortable. How do you think you would handle these situations, both when they occur and after the situation has ended?
3. If you felt your job was causing an increase in your stress level, what would you do? *(Answer should include seeking supervision and NOT include anything about going to other staff in a "patient" kind of way.)*
4. Can you tell me about your history of dependability in prior positions (or, if no recent positions), in other activities in your life? *(You CAN ask this. You CAN NOT ask history of hospitalizations, history of taking medical leave, or when someone was "last sick".)*
5. Do you function better with the independence to create your own work structure, or do you work better with a clear structure?

6. Some people are here because they have been found not criminally responsible for serious crimes. Those crimes range from theft and arson to rape and murder. Some may have been high profile and you may have read or heard shocking information about them in the media. What are your thoughts and feelings on working with people in this situation?
7. Can you tell me about a time you experienced a conflict with a co-worker? How did you handle it? *(Or, alternately, ask about a time they experienced a conflict with a supervisor. Do not just ask this question in a 'yes' or 'no' format, as it becomes much less likely to elicit useful information.)*

Action Tool: Wellness Plan

Wellness Plan

This plan is written, maintained and kept by **YOU**. This is **YOUR** plan. It can be helpful in guiding the conversations between **YOU**, and your COACH.

What is my overall goal?

It is often helpful to break down wellness into smaller parts; these will be listed below. Under each heading, you will find some questions to get you thinking. Some will strike you as more important than others – please pay attention to these. There is an opportunity to set a goal under each heading, yet you do not need to have a goal under each heading. Oftentimes, it gets confusing to have more than a few goals at a time.

1. Connection to MY Community
<ul style="list-style-type: none"> • Do I have contact on a regular basis with people who do not use drugs/alcohol? • Am I or do I want to be involved in a drug free support group? • Am I or do I want to be involved with a faith community? • Do I spend social time with others who do not use drugs/alcohol? • Other questions I should be asking myself?
Wellness Goal

Steps I need to take to reach my goal
Who else might be involved?
When do I want to have this goal accomplished?

2. Physical Health

- Do I eat a balanced diet?
- Do I exercise regularly?
- Do I get enough sleep?
- Do I need to see a doctor or dentist?
- If I have been prescribed medication for my physical health, am I taking it as prescribed?
- Other questions I should be asking myself?

Wellness Goal

Steps I need to take to reach my goal

Who else might be involved?

When do I want to have this goal accomplished?

3. Emotional Health

- Do I work at being in healthy relationships?
- Am I seeing a therapist/counselor or need to be seeing one?
- Am I happy most days?
- Do I talk about my emotions?
- Other questions I should be asking myself?

Wellness Goal

Steps I need to take to reach my goal
Who else might be involved?
When do I want to have this goal accomplished?

4. Spiritual Health

- Am I comfortable with my spirituality?
- Do I need to develop a spiritual sense and spiritual practices?
- Am I disciplined about my spiritual practices?
- Do I take time each day for prayer, meditation and/or personal reflection?
- Any other questions I should be asking myself?

Wellness Goal

Steps I need to take to reach my goal

Who else might be involved?

When do I want to have this goal accomplished?

5. Living Accommodations

- Does where I live support me?
- Does who I live with support my choice to stop using drugs/alcohol?
- Do I need to make any changes in my living situation?
- Any other questions I should be asking myself?

Wellness Goal

Steps I need to take to reach my goal

Who else might be involved?
When do I want to have this goal accomplished?

6. Job/Education

- Do I have or need a job?
- Am I satisfied with my education?
- Do I need to return to some form of education?
- Do I need assistance with my education (tutoring)?
- Any other questions I should be asking myself?

Wellness Goal

Steps I need to take to reach my goal

Who else might be involved?

When do I want to have this goal accomplished?

Other

- Are there other areas I wish to explore?

Wellness Goal

Steps I need to take to reach my goal

Who else might be involved?

When do I want to have this goal accomplished?

**Participant's
Signature**_____

Date_____

Coach's Signature_____

Date_____

Action Tool—Peer Boundaries

PEER BOUNDARIES

Do's:

- Do maintain a professional and respectful attitude toward the individuals and peers you work with regardless of your previous relationship.
- Do respect the confidentiality of the information you receive from the peer seeking services. You are bound by the federal HIPAA HITECH privacy rules.
- Do know your limits. Ask for help before you get overwhelmed with peer's problems.
- Report concerns "up", but not "out". That means if you feel you should report confidential information, here is the "up" list: your supervisor, the program director, or the Compliance Officer.
- Report concerns about workplace harassment to your "up" list.
- Report concerns about emotional or mental problems to your supervisor.
- If you know someone is being hurt: for example, child abuse, spousal abuse, elder abuse, potential suicide or homicide, you must report it right away to someone on the "up" list. You are not the after-hours crisis response staff. Be sure to provide peers with after-hours crisis numbers at first contact.
- Do not share your personal contact information with peers you are providing services to such as your personal cell number.
- Understand that once you report the situation, it then becomes confidential information to the person to whom you report it, and you will not receive follow-up information. Just continue to be an empathetic mentor to the peer but do not ask for further disclosure on that topic.

Don'ts:

- Don't discuss your participants with your family or friends.
- Don't try to solve the peer's problems by yourself. Your peer is an adult and has responsibility for his/her own life. You are not a therapist.
- A romantic relationship is **inappropriate**. You are his/her Peer provider, and need to
 - maintain a professional distance. You are the more powerful figure in the relationship and don't want to put pressure on the participant.
- Don't communicate by touch. It can be misinterpreted and can make the person uncomfortable.
- Don't make sexually suggestive remarks, gestures, jokes, touches, or teasing. What may be funny to you can be sexually intimidating, hostile, or offensive to another person.
- Don't get discouraged. Mentoring is a process, and does not get instantaneous results.

Action Tool: For the Peer Receiving Services

Guidelines for Protégé/Mentee/Peer Relationships

Here are some guidelines to help you in developing a good working relationship with your Peer provider.

Your peer provider (mentor) will:

- offer you support and encouragement;
- help you develop the personal and academic/job skills necessary to be successful;
- help you clarify your personal and professional goals; and
- offer himself /herself as a person you can talk to.

You will:

- be sincerely interested in developing a good working relationship with your peer provider;
- be as clear and specific about your needs as you can;
- commit to have regular contacts with your mentor; and
- commit to carry out agreed upon goals and action plans.

Confidentiality:

- Your mentor will respect the confidentiality of the information he/she receives from you.
- Your mentor will report confidential information only in the case of someone being hurt, for example, child abuse, spousal abuse, elder abuse, potential suicide or homicide. Your mentor would report this information to someone on the “up” list: either to-his/her supervisor, the program director or the compliance officer
- Your peer provider will tell you if he/she feels that this kind of information must be reported.

Workplace Harassment

- A romantic relationship with your peer provider is **inappropriate**. Your peer provider should not put any pressure on you to have a romantic relationship or vice versa.
- If you feel pressured or harassed, you should immediately make your displeasure clear to your peer provider.
- If the pressure continues, you should report it to the organization’s program director, CEO and or compliance officer.

Action Tool: Cultural Competency

Cultural Activation Prompts (CAPS) & Cultural Formulation Interviewing

Cultural Activation Prompts (CAPS): A Tool to Promote Cultural Activation is a list of 12 cues for individuals to use to convey information to caregivers on what culturally matters to them in receiving care.³⁷

Cultural Formulation Interviewing, an evidence-based tool, is composed of a series of questionnaires that assist clinicians in making person-centered cultural assessments to inform diagnosis and treatment planning.³⁸

37 https://www.leaders4health.org/images/uploads/files/Reid_Rose_Cultural_Activation.pdf

38 <http://www.multiculturalmentalhealth.ca/clinical-tools/cultural-formulation/>

Maintenance

Supervision

Here are the tenets of good supervision overall:

“Good supervisors are available, accessible, affable, and able. The general picture of the “good” supervisor shows himself/herself to be a person who is a technically competent professional, with good human relations skills and good organizational-managerial skills. The supervisor accepts, is comfortable with, and appropriately implements the administrative authority and power inherent in the position in a non-authoritarian manner; holds workers accountable for assigned work and sensitively, but determinedly evaluates supervisees carrying out of their assignments; balances support and clear expectations of work in conformity with clearly defined performance standards; provides clearly structured procedures and constructive feedback for workers in their relation to the agency and their duties; and makes active efforts to integrate agency’s need for production with the socio-emotional needs of the workers.”³⁹

The peer provider’s role is unique. The peer is not a “mini-therapist” or a junior clinician. Instead, the peer’s lived experiences allow them to fulfill a specific role in a person’s recovery process. This role sometimes conflicts with older medical model ideas about treatment, which may discourage the unique relationships peers can develop with individuals through sharing their recovery stories. Peer supervision is also unique. Here are some important guidelines for the supervisor in peer supervision. The supervisor must:

- look for strengths in the peer;
- value the lived experience that the peer brings to the work of the agency;
- understand the values of peer-to-peer services;
- know clearly the role of the peer and what can and cannot be done in that role;
- ensure that the peer is given tasks appropriate to the job description;
- give constructive feedback;
- can work through ethical, boundary and other issues related to peer services;
- understand the role of mutuality in the peer-to-peer relationship;
- can admit that he/she does not have all the answers, but seek information to answer questions to the best of his/her ability;
- understand the code of ethics for peer workers;
- work with management to ensure ongoing training for the peer;
- allow the peer to ask questions and give feedback; and
- work with management to ensure ongoing training for the peer.

In addition to individual supervision sessions, having regular group supervision for peers allows them to act as supports for each other, and to learn skills to maintain their unique peer support roles. We recommend group supervision for peers at least monthly to allow a community of fellowship and mutual support to develop among the peers at your organization. If not done competently, group supervision can become dominated by a single individual or become the place where peers “vent”

³⁹ Kadushin, Alfred and Daniel Harkness, *Supervision in Social Work*, 4th ed., Columbia University Press, 2002

their frustrations without offering solutions. To avoid this, it is helpful to utilize such techniques as *Six Thinking Hats*. (See Maintenance Tools at the end of this section.)

Setting the stage for individual supervision and the interpersonal aspects of the peer/supervisor relationship are key:

- Work to develop a sense of mutuality in the relationship.
- Aim for both the peer and the supervisor to be open and curious about supervision.
- As a supervisor, it helps to simply state that your intention is to develop this type of supervisory relationship. (Matthew Chinman, 2013)

Peer support is a strengths-based process. The peer supervisor has a responsibility to create a supportive context for peers to expand their roles and identity development. During supervisory dialogues, encourage peers to share their personal strengths and beliefs. You can simply ask, “How do you define your own strengths?” Later, you can discuss what strengths peers see in the individuals they serve. Encourage peers to explore and be curious about the role of peer support for participants. Encourage peers to develop an agenda for individual supervision and to submit it in advance so that both the peer and the supervisor come to the supervision prepared. (See Maintenance tools at the end of this section.)

Note: For an in-depth resource on SUD peer supervision competencies, please see the following resource—Substance Use Disorders Peer Supervision Competencies.⁴⁰

⁴⁰ http://www.williamwhitepapers.com/pr/dlm_uploads/Peer-Supervision-Competencies-2017.pdf

Maintenance Tool: Supervision Resource

SIX THINKING HATS

This metaphor that de Bono suggested (2008), of wearing one hat at a time, is an apt one in supervising individuals in group as the technique indicates a structural sorting out of the problem-solving process. When wearing a specific color hat, the rule is that everyone in the room must think from the perspective of that hat.

The rule of everyone wearing the same color hat is that they jointly explore the situation from that perspective exclusively. Everyone then removes that hat and puts on another color hat to think differently about the same problem, while all continue to think alike. Like the classic Gestalt empty-chair technique, the six thinking hats is the equivalent of structurally moving from one chair then changing the focus when moving back to the other. For example, when a group wears the green hat, they imagine creative solutions to the presenting problem. Since they are wearing the same color hat, their thinking is aligned. Rather than discussing that the problem has no solution, counselor interns are encouraged to take an “as if” stance, brainstorming creative solutions to a seemingly intractable problem. The process explores only one component of parallel thinking at a time, allowing individuals the reflection time they need to be effective communicators.

1. The **white hat** represents pure knowledge gathering, data collection, and historical account. It asks, “What do we know?” It addresses cognition. The process involves exploring facts rather than personal opinions. “First class” facts consist of ones that are checked and proven, while “second class” facts include information believed to be true. Information that is missing is also included here. The white hat covers facts, figures, information needs and gaps.
2. The **red hat** represents feelings and hunches. This hat legitimizes emotions and explores fears, likes, dislikes, loves, and hates. This hat legitimizes emotions and feeling by focusing on “This is how I feel.” It addresses affect by focusing on hunches, intuition, and signal. The red hat is the opposite of neutral, objective information (white hat). Here there is no need to give reasons or justification for the subjective feelings.
3. The **black hat** focuses on critical negative judgments, a risk analysis. It identifies cautions, dangers and potential problems. It is the logical negative and addresses possible negative effects and what may potentially happen. It can be used to determine weakness in an idea. It also addresses why it does not fit—facts, experience, policy, system and ethics. It asks, “What may be hazardous?” The black hat thinker is a gatekeeper, not a dream breaker.
4. The **yellow hat** symbolizes sunshine, brightness and optimism; it is positive and constructive. It addresses feasibility, benefits, advantages, and savings. It asks, “What could happen (positive)?” The yellow hat addresses reframing and permits visions and dreams. Yellow Hat thinking helps keep the group going when everything looks gloomy and difficult.
5. The **green hat** symbolizes fertility, growth, and the value of seeds. It involves creative thinking and the search for alternatives while generating new concepts and new perceptions. The green hat is the “thinking outside the box” creative hat. It asks, “What haven’t you considered before?” It involves brainstorming and free association which explore new possibilities, alternatives, ideas, and concepts.
6. The **blue hat** represents the management of the thinking process. Blue hat thinkers are like the orchestra conductors seeking the proper balance and blending of the other five hats. It asks, “What is the conclusion?” Blue hat thinking is a final reflection on the other five hats that have been both over and under-utilized in the problem-solving exploration. The blue hat is also responsible for summaries, overviews, and conclusions,

Wellness

In this phase, the program has concretely integrated peer services, and is looking to maintain strong peer-to-peer services. Peers operating in an effective manner will maintain a “peer identity.” We define the *Wellness* phase as (ongoing maintenance vs. relapse). The following are examples of “peer identity vs. peer drift” which is a form of relapse in the Stages of Change Model.

PEER IDENTITY	PEER DRIFT
- Comfort using recovery story as tool	- Discomfort using recovery story as tool
- Peer support relationship as mutual learning experience between peer and participant	- Peer support relationship is used as an opportunity for expert instruction by informed/recovered Peer to the participant
- Focus on participant strengths, skills, and opportunities	- Focus on peer problems, barriers, symptoms and diagnosis
- Striving to keep interactions with peers simple, authentic and real	- Distant interactional style that focuses on more professional and objective standards rather than on subjective and flexible human connections
- Advocate for individuals to find their own voices, make self-determined choices, and take calculated risks in service of recovery and related goals	- Encouraging individuals to comply with professional advice, defer decisions to others, and avoid challenging situations that may be stressful (and symptom inducing)
- Self-confidence, security, and pride about identifying as a peer	- Self-doubt, insecurity, and shame about identifying as a Peer

Source: (Matthew Chinman, 2013)

How will illnesses of all types be addressed?

At some point, all employees get sick and cannot perform their duties adequately, and need to take time off. Although psychiatric or substance use relapse is not common, it does happen. In fact, symptoms associated with behavioral health are already a significant cause of sick days for many employees, not just peers. If a peer becomes symptomatic to the point that he or she cannot perform the job, sick time should be taken. However, peers should not be expected to take additional or less sick time than any other employee. As in other jobs, it is not the role of the supervisor to determine whether the peer is starting to relapse or become symptomatic. However, pointing out behaviors that may be of concern can be useful, if handled tactfully. For example, supervisors would not diagnose a bad cough, but they may tactfully suggest getting an examination, if an employee was ignoring the problem. Finally, peers, like other employees, need to know that they can return to their jobs when they are well enough to perform their duties satisfactorily. Like all other employees, peers should be informed of the organization’s policy on extended sick leave.

Performance Evaluation

How will the performance of the peer providers be evaluated?

The performance of peers should be evaluated just like that of all other employees. For example, peers should be evaluated per the same schedule as other employees and evaluations should be limited to job performance, as with all other employees’ evaluations. While there are certain aspects of a peer’s job performance that overlap with other providers (i.e., maintaining professional relationships co-workers, supervisors, and clients), the evaluation should also be tailored to the specifics of the

unique role that peers play. For example, regular peer responsibilities include wellness planning or self-advocacy with clients. A peer's evaluation should include how well he or she accomplishes these activities. In addition, it is commonplace for employees to rate themselves per the same standardized criteria used by employers. The employer reviews this self-appraisal, which then becomes part of the overall evaluation process. (National Center for Interprofessional practice, 2010)

Under current employment laws, an employer must never 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 must tolerate or excuse violence, threats of violence, stealing, or the 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 involved in the current altercation? Or is the employee with the behavioral health condition perhaps expected to comply with counseling through the agency's Employee Assistance Program (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.

A person with a disability, behavioral health or otherwise, may be terminated if he/she is unable to perform the essential functions of the job. However, the employer is obligated to first make attempts to provide reasonable accommodations 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.

Risk Assessments and Controls for Peers Who Work in Homes/Community

Agencies that integrate peers will most likely utilize the peers to do services in the community and some of these services can be in the participant's home. It is important to establish and maintain an organizational culture that promotes safety and security for all staff, but it is particularly important to understand that there must be a determined focus on safety for peer workers, as this is a new line of business and we are entering uncharted territory with this service which carries with it human dynamics.

Providers understand that an employer has an obligation under the Workplace Health and Safety Act 1995 to provide a healthy and safe workplace for themselves, their workers, including agency staff and subcontractors, and anyone else in the workplace. The workplace for this industry includes private homes, apartments, and other community settings. Providers working with peer-to-peer services face new challenges with Peers working in the community, but even more of a challenge when in the community also means in individual's homes. In addition, for many providers, working with peer services is new, therefore, developing policies and procedures may be a challenge.

It is important to note that peers working in the community or making home visits have little control over their work environment which may contain several different types of safety and health risks. These risks can include dangerous environmental conditions, violence, hostile animals, and biological hazards (communicable diseases and nuisance infestations).

Policies and Procedures and Risk Assessment

The provider must identify risks of working in the home or community, and go over these risks with the Peer before sending them out to provide services. The goal is to identify potential risks and put appropriate controls in place. This should be done through developing policies and procedures for the Peer provider around risks and safety issues. Here are some ideas to focus on during the development of the safety policies and procedures:

Dangerous Environmental Factors

Is the community an environmental risk for the peer?

Does the peer provider have a negative history with the community? Are there community factors that are triggering to the peer—prior gang activity or significant drug experience in the community?

Controls

- Be aware of areas where the participant lives and where the peer has history that may get in the way of positive outcomes.
- Avoid having peers work alone or wearing jewelry in known drug areas, isolated places, or high crime areas.
- Develop response measures for the peer when they face certain situations to reduce risks and injuries or other harm, such as, the use of a cell phone and notification of supervisory staff in areas or situations that seem unsafe.
- Identify risks that the peer may face in doing work in the home or community—will he/she be working in areas that may be unsafe—i.e., prior drug or gang affiliation in the area.
- Are there factors in the home of the participant that are risky for the peer provider? For example, does the peer have a condition such as asthma.
- How many people reside in the home? Will there be other people in the home during the session?
- On the assessment for the peer service, find out the layout of the building, and is there an elevator?

Violence

Does the participant have a history of violence?

Control

- Before going into the field, the provider assessment should gather information, which can be provided as background before meeting with the peer about the visit—who is in the home; who is expected to be there at the time of the visit. The peer should also be given background on current status of the participant through the interdisciplinary team meeting. This information can include whether the participant has had prior violent encounters with the police, schools, a history of mental health issues, history of violence, etc. Some of this information can be gleaned from agency records. Additional information may be obtained from informal sources such as supervisors and other clinical or peer staff.

Peer workers must understand threatening situations including the nature of violence. Violence includes physical assault, verbal assault, harassment and the threat of assault.

Animals

Does the participant have an animal in the home?

Controls

Animals such as dogs and cats can be a risk for staff that work in the community and in homes. When a visit is being set up in the home, the following information should be ascertained pertaining to animals in the home:

- Make the peer provider aware of what to do and not do around dogs.⁴¹
- Is the dog in the home aggressive?
- Is the participant agreeable to putting the animal away during the home visit?
- Are there animals in the home such as dogs or cats that the peer provider is allergic to?

Biological Hazards

Is the peer provider prepared to understand the risk of biological hazards?

Bed bugs and other parasites, such as scabies, are problems that can be faced in the general population by anyone. Occupations that require exposure to homes and facilities put workers who provide services in the home at risk for bed bug infestations and other infestations.⁴²

Is the individual being served under treatment for a communicable disease such as Tuberculosis (TB) or Influenza? Has the peer provider received training on infection control?

Controls

- Before making a home visit, all participants should be asked, in a matter of fact way, whether they have had any pest infestations in the home in the past six months. Reassure the participant that this is a problem anyone can have and that these parasites are in hotels, movie theaters and many homes and places in New York and around the country.
- Make sure staff is aware of universal precautions⁴³ infection specifics.
- Control measures should be put in place after the assessment and determination that the individual would be a good candidate for peer-to-peer services, specific to the findings of the community and home risk assessment to be developed by the provider.
- Identify risks for the peer service in the office, community and home.

Following are suggestions for the peer-to-peer services risk assessment:

- Assess and prioritize risks – some risks are of less of a safety priority than others.
- Control measures should be developed and in place as policies and procedures; and these control measures should be identified while developing the participant's care plan.
- The next step is to implement and discuss the control protocol with the peer; monitor and revise the control; keep records and discuss issues that arise related to the control with the peer; make changes to the control; adjust the risk level and/or control as needed.

⁴¹ <https://www.publichealthmdc.com/environmental/animal/DogBitePrevention.cfm>

⁴² http://www.expedienthdc.com/Websites/expedienthdc/images/Managing_Bed_Bug_Infestations_JA.pdf

⁴³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4597924/>

Safety Tips for Peer workers in the Community and Home

The need for personal safety information is imperative to provide preventive strategies to enable peers and other staff to be safe.

The following are a few safety strategies for peer workers:

- Before meeting with the participant, consult with your supervisor and/or staff with more experience with specialty areas (i.e., Mental health/substance use) if you have safety concerns about a participant in an area that you are not that familiar with.
- Always travel with a cell phone that is charged, turned on, and preprogrammed to your employer and to call 911 for assistance in any emergency or threatening situation.
- Before you knock on the door of the person's residence, briefly ascertain if there are any disturbances such as screaming, yelling, or fighting before you knock. If you hear such disturbances, leave and reschedule the appointment for another time and perhaps a different setting.
- Before opening a gate, rattle it to determine if there are dogs are loose that might pose a threat.
- Do not enter premises, if a threatening animal is present, and not put away.
- Upon arrival ensure the individual and/or family members know who you are and why you are there. Confirm the name of the individual or family members that you are providing peer-to-peer services to if it is your first time meeting the person.
- Be sure to present your agency ID card/badge. Do not present your credentials to anyone else unless asked to do so.
- Do not attempt to hold home visit if the individual you are there to provide services to or others in the home are inappropriately dressed.
- During the meeting, assess the person/persons you are interviewing to determine their demeanor, and/or if they are under the influence of any substances. Also, note any drug paraphernalia lying around.
- Do not attempt to hold a home visit if people appear to be under the influence of alcohol or other drugs, or if there are other people in the home that you feel uncomfortable with. However, if you are there to accompany the peer to detox or medical services, and the peer is under the influence, this may not apply. Discuss this within the policies and procedures with your supervisor.
- Do not share your home address, and be careful what self-identifying information is on social media accounts such as Facebook. You may want to give the peer your business cell phone, but sharing your personal cell phone number should be discussed with your supervisor, and/or what you feel comfortable with sharing.
- When making a first-time home visit to a participant's home, check in with your agency at pre-determined times to let them know you are okay. For example, you may want to make contact at the end of a scheduled home visit.

- Trust your instincts—If something doesn't feel right and you are uneasy about the situation you are in, leave and call your supervisor.
- If you believe your safety is threatened, remove yourself immediately from the situation; call your supervisor; document the incident, and file in the record folder. Discuss with your supervisor alternatives ways to serve the peer. Your supervisor may alter, the service plan in order that you meet with the participant in a public place, community or service center or in the provider program.

Closing

In 2015, there were 20.5 million people, ages 12 and older, who were diagnosed with a substance use disorder. (American Society of Addiction Medicine, 2015). The idea that, as a society, we can treat this epidemic without the insight of those who struggle and manage it daily, is shortsighted. So, what are our institutional barriers to achieving the goal of peer service integration? To answer that question each organization must take a close look at itself, and ask if peer services actually is a goal or just a current trend that they want to follow. Then, each organization needs to determine if they can accept persons who can serve as change agents, who may not present in a way you are used to or comfortable with. This toolkit provides not only the tools needed to integrate peer services, but also the instructions on how to use them. Now it is up to each organization to decide, if they want to pick them up and get to work.

Attachment A

Peer Services in Residential Part 820 Settings

State and National Medicaid Redesign Initiatives recognize the critical role that substance use disorder (SUD) treatment services, including residential services, play within the full continuum of care required to meet the triple aim of:

- improving the quality and experience of care;
- improving the health of populations through access to care; and
- reducing per capita costs of health care.

These exciting times offer our field tremendous opportunity to improve the quality of care by enhancing staffing and services. Part 820 Regulations were designed to integrate:

- Part 819 Intensive Residential;
- Part 819.9 Community Residence;
- Part 819.10 Supportive Living; and
- Part 816.9 Medically Monitored Crisis Services.

The Residential Redesign paradigm was designed to allow providers flexibility in the provision of clinical services. The focus is on good clinical practice and services that are participant centered, trauma informed, strength based and recovery oriented. Key to the transformation is the integration of medical, mental health and SUD services. These services are now reimbursable through Medicaid Managed Care, which will allow the care system to reinvest cost savings, and revenue into providing evidenced-based and best practices into the delivery framework; most notably Peer Coaching and other Recovery Supports.

The clinical underpinnings of Part 820 are clearly congruent with the peer services role in a Recovery Oriented System of Care and can be reinforced within the scope of practice and skill sets of peer recovery advocate and/ or recovery coaches. Services correspond to specific elements of treatment, which are distinguished by:

- configuration of services;
- staffing patterns; and the
- degree of dysfunction of individuals being served.

Services focus on one or more of the following elements:

- stabilization;
- rehabilitation; and
- reintegration.

Stabilization requires the supervision of a physician and clinical monitoring to address:

- mild to moderate withdrawal;
- severe cravings; and
- psychiatric and medical symptoms.

Rehabilitation is designed for individuals with significant functional impairment in the following areas:

- social;
- employment;
- inability to follow social norms; and
- housing.

Reintegration in a congregate setting or scattered site setting will provide:

- opportunities to actualize skills learned in treatment in the community;
- linkages to community services/resources; and
- services for those transitioning to long-term recovery and independent living.

Movement through the elements of care are determined by the participant's risks and resources. Therefore, the movement may not be linear.

Example 1

Richard had numerous treatment episodes and presently has an apartment, a job and was connected to Outpatient Services when he relapsed. He requires the stabilization element of care as indicated by the LOCADTR 3.0 and will not need the full continuum of Part 820 elements of care (rehabilitation or reintegration).

Example 2

Patricia is on parole and recently relapsed. She lacks community support, housing and employment skills. The LOCADTR 3.0 indicated rehabilitation and she will possibly need the continuum of Part 820 Elements of Care (Rehabilitation and Reintegration).

In both case studies the participants, would benefit from the interaction with a recovery peer advocate and/or recovery coach to ensure better outcomes.

Considerations:

Historically treatment utilized peers within the residential community as role models, escorts, and mentors. An unintended consequence of Part 820 transformation is that peers within the residential community will lack the experience to fill the roles described above. Due to person-centered, participant driven lengths of stay there will be a gap which certified peer recovery advocates and/or recovery coaches can fill easily utilizing their life experience.

Recruitment of Peer Recovery Coaches for Part 820:

Prior to implementation of peer services in the Part 820 residential setting, the agency needs to consider the following:

-
- The provider should explore whether the program will employ peers from within the program or hire from the community at large. Providers should develop strategies when employing peers from within the program; including how peer advocates will be implemented into your program structure, redefining roles for the former participant and staff team; developing professional boundaries within the milieu; and the impact on the former participant's own recovery process.
-
- Integrating the recovery peer advocate and/or recovery coach into the interdisciplinary team and defining their scope of practice.
-
- The peer's skill set and focus based on life experience, and professional experience is relevant in matching the peer to the specific element of care.

- Recovery coaches/peer staff should not be overnight staff or other clinical treatment based positions, they are to provide specific recovery supports. It is not in the scope of practice for them to do clinical interventions.

Considerations for each Element of Care:

Stabilization: Peer navigation and engagement has already been proven efficacious in supporting participants as they transition into and through the care system at the point of detoxification and referral to the next level of care. Peers can effectively provide support upon discharge from a hospital based detox into a Part 820 residential program Stabilization element of care or as they transition within Part 820 services from Stabilization into another element. Peers enhance various treatment performance outcomes, through the provision of ancillary support and engagement and when coupled with evidence-based treatment makes the experience of care to the participant more authentic.

Rehabilitation: Wrap around services for our SUD participants were traditionally managed in an outpatient setting. Residential systems did not have the integrated method or the workforce to effectively enhance systems around the participant (and family) to ensure that gaps were addressed. Recovery peer advocates and/or recovery coaches can be placed in various points of the residential design to collaborate with providers in delivering psycho education; wellness and recovery planning; positive socialization; and various system supports as the resident encounters stressful interactions with agencies and systems. Peer navigation through these broader systems reduces anxiety, stress and relapse potential as the resident encounters many different journeys back and forth from the community into the safer, residential construct. By accompanying and supporting residents, the risk of relapse and other symptoms are greatly reduced, thus improving recovery outcomes and providing lasting linkages to the community.

Reintegration: Certified recovery peer advocates from a Part 822 outpatient provider can be utilized, if the provider agency does not have peer coaches or peer advocates. The option of accessing Home- and community-based services through health homes is available in the reintegration element of care for scatter-site settings not congregate care settings. When an individual is found eligible for HCBS peer empowerment services this option should be utilized. In the reintegration element of care, recovery peer advocates are essential for smooth transition to community-based services. These recovery services support participants during a critical juncture in their process.

Concrete Ways that Peers can be utilized in Part 820

There are many ways to utilize recovery coaches in residential settings. Peers should be used to:

- assist in navigating other systems;
- teach people how to appropriately advocate for themselves;
- work with the drug court team;
- assist persons during crisis situations;
- ensure warm hand-offs between elements of care (moving from rehabilitation to re-integration in the community) and levels of care as well as the linkages to community resources;
- work with the person from the beginning of treatment and stay with the person through the elements of care and levels of care (Other staff may change, but the Peer Advocate remains constant for fostering stability.);
- function as a cheerleader, motivator, a big brother/sister;
- provide emotional support—reducing anxiety;
- assist in the person's acclimation to new residential environment, increasing retention; and
- bring different perspectives to the treatment interdisciplinary team through the lived experience.

Funding for Peer Services in Residential Settings

Part 820 Providers are being encouraged to integrate Peer Services in all elements of care. These essential peer recovery advocate services are not directly reimbursable by Medicaid Managed Care at this time. However, as value-based payment methodology and contracts become the routine reimbursement method, peer services and other ancillary options will strengthen the proposal of the provider to the Managed Care Organization. Subsequently, residential providers should contact their OASAS field office coordinators to negotiate adding peer services into their budgets to foster successful outcomes. Providers can research grants that may fund peer services, etc.

Training for Part 820 Peers

Training peers for Part 820 should embody the concepts of being person-centered, strength-based, trauma-informed and recovery-oriented. Other trainings should include, but are not limited to:

- sharing lived experiences in an appropriate manner;
- strength-based, trauma informed and recovery language;
- understanding medication assisted recovery;
- ancillary withdrawal;
- measurement based care tools; and
- utilizing assessment tools to develop base lines to measure progress. (i.e., Recovery Capital Scale).

Actual Provider Clinical Visions of Integrating Peer Services into Part 820 from the Provider Community

Agency A

We plan on utilizing peer support specialists to facilitate participant progress by providing support to recovery oriented activities. For stabilization clients, the recovery peer advocate will work with participants in groups to provide support and encouragement in the engagement stage. They will help participants learn to advocate for their treatment. They will assist with accompanying participants into the community for medical or benefit appointments to ensure successful linkage. For the rehabilitative participants, the peer will work on integrating participants back into the community and connecting them to identified community related supports that the participant would find helpful. These activities will include how to become involved with an AA/NA or smart recovery group, how to find sober socialization areas, locating activities that support recovery, and supporting a weekly alumni group for mutual aid and support.

Agency B

Our agency has extensive experience and expertise in successfully operating an array of peer delivered services throughout the agency as peers provide various levels of mentoring, guidance, education and community outreach. Our values and mission support roles for peer workers and have proven to foster ongoing wellness and housing stability as evidenced by the fact that individuals who received peer support have improved wellness scores, are more engaged in treatment adherence, and can successfully maintain stable housing even after transitioning out of services. We already have well established systems and protocols developed to select, train and supervise peers. Our HR team is well versed in peer services and has clear criteria for hiring, understands policies that may impact hiring, and is aware of potential peer employees' status regarding disability benefits, recruitment success will occur both internally, through identifying individuals who have the shared experience and capacity. A team of peer recovery coaches will be embedded within the program to enhance peer based recovery services into long-term recovery planning for everyone served. The program will work closely with care management to ensure residents are assessed for all HCBS services upon discharge from the program. Our agency already has a customized training track for peers which includes free online state certification trainings. Peers will receive training on communication skills, cultural competency, client confidentiality, harm reduction, stigma, self-disclosure and appropriate evidence based

interventions, along with OASAS Part 820 regulations and program policies. Certified peer recovery coaches will provide pro-social behavioral interventions to our residents and will link them to supports and services, within the community. This unique partnership of sharing will make the relationship and experience more meaningful and will promote greater possibilities for change. Peer recovery coaches will work closely with members to assist with guiding them through the recovery process in a supportive and collaborative way that is helpful to the individuals using intentional peer support. This approach will create new ways of seeing, thinking, and doing and a partnership will form that will enable both parties to learn and grow, rather than as one person needing to 'help' another; ultimately drawing on knowledge and skills acquired from personal experience with the medical, MH/SUD and legal systems with a focus on every individual's personal recovery process.

Attachment B

Recovery Oriented Language

***Changing the Language of Addiction*⁴⁴**

It is important that as we develop peer services as a part of a Recovery Oriented System of Care, we use language that is empowering, current and non-stigmatizing. The following language is excerpted from a document entitled *Changing the Language*, by Michael Botticelli, former Director, of the White House Office of Drug Control policy in 2017. This is the current suggested language:

Substance Use Disorder

The current Diagnostic and Statistical Manual of Mental Disorder- (DSM-5) replaced older categories of substance “abuse” and “dependence” with a single classification of “substance use disorder.” Terms such as “drug habit” inaccurately imply that a person is choosing to use substances or can choose to stop. “Substance use disorder” is the clinically accurate term to describe the constellation of impairments caused by repeated misuse of a substance.

Person with a Substance Use Disorder

Person-first language is the accepted standard for discussing people with disabilities and/or chronic medical conditions. Research shows that use of the terms “abuse” and “abuser” negatively affects perceptions and judgments about people with substance use disorders, including whether they should receive punishment rather than medical care for their disease. Terms such as “addict” and “alcoholic” can have similar effects. Thus, terms such as “person with a substance use disorder” or “person with an alcohol use disorder” are preferred.

† Note that some statutory provisions continue to use older language, including certain agency or organization names. The United States also continues to be a party to some international agreements that use older, nonmedical terminology. In communications related to those agreements, use of up to date medical terminology is encouraged when feasible and practical. We would encourage the use of updated language as these provisions are periodically revised and in other legislation addressing these issues.

Person in Recovery

Various terms are used colloquially to label the substance using status of people with substance use disorders, including the terms “clean” and “dirty.” Clinically accurate, non-stigmatizing terminology that is like how we describe other medical conditions is strongly preferred. Instead of “clean,” the terms “negative” (for a toxicology screen) or “not currently using substances” are preferred when describing a person. Instead of “dirty,” the term “positive” (for a toxicology screen) or “a person who is currently using substances” may be used. The term

⁴⁴ <https://obamawhitehouse.archives.gov/blog/2017/01/13/changing-language-addiction>

“person in recovery” has a range of definitions but generally refers to an individual who is stopping or at least reducing substance use to a safer level, and reflects a process of change. A person can be in recovery while taking medications and/or receiving psychosocial services.”

Medication-Assisted Treatment/Medication

With respect to the use of medications in the treatment of substance use disorders, the terms “replacement” and “substitution” have been used to imply that medications merely “substitute” one drug or “one addiction” for another. This is a misconception. When someone is treated for an opioid addiction, the dosage of medication used does not result in a “high,” rather it helps to reduce opioid cravings and withdrawal, restoring balance to the brain circuits affected by addiction and allowing the patient’s brain to heal while they work towards recovery. The term “medication-assisted treatment” (MAT) is used to refer to the use of any medication approved to treat substance use disorders combined with psychosocial support services. “Medication” refers to a specific FDA-approved drug for addiction treatment such as buprenorphine, methadone, or injectable naltrexone (for opioid use disorder), and naltrexone, disulfiram and acamprosate (for alcohol use disorder).

As a quick reference:⁴⁵

- Use “substance use disorder” as opposed to “abuse” or “dependence.” You can also use “misuse” instead of “abuse”.
- Use person-first language: a person with a substance use disorder or struggling with addiction, not an addict, junkie, druggie, etc.
- Refrain from using “dirty” or “clean” when talking about drug use; instead say someone is in active addiction or is substance-free or in recovery

⁴⁵ <https://aboveitalltreatment.com/blog/changing-language-addiction-recovery/>

In a shifting health care field that has a desire to become more recovery-oriented, we regularly hear from communities, systems and organizations the question – “can you give us an example; tell us or show us a community that has achieved this?” It’s the same for individuals and families who have the same desire to shift and transform their lives. They want and deserve our efforts to motivate them; to walk alongside them; and to show them that they are capable, brave and significant even when it feels like they’re not. They are deserving, worthy and can have the life that they dream of. Who better than a peer to serve as that shining light and example of the way forward. – **Lonnetta Albright**

