

# A Curriculum for Supervisors: Supporting and Learning from the Peer Workforce



Updated July 2016



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This training, funded by the Massachusetts Department of Mental Health (DMH), is primarily for supervisors of Certified Peer Specialists (CPSs) who are not CPSs themselves. In other words, people who have been trained in other fields of practice who are now being asked to take on a supervisory role with incoming CPSs. However, the information will be helpful to all supervisors.

Ideally, CPSs should receive at least part of their supervision from another CPS with more experience who can assist the person to grow and develop in their professional capacities. However, the CPS field is new to the State, with many agencies having only one or two CPSs, neither of whom has the skill or experience to take on a supervisory role. This training is meant as a “stop-gap” effort to provide guidance and education about CPS practice for non-CPSs who are or will be asked to fulfill that supervisor position.

CPS practice is based on relationships, and it’s hoped that this training will help build a strong relationship between you, the supervisor, and the CPS supervisee(s) you’re working with. To support this partnership, each module in this training offers exercises that include your supervisee(s) in order to open dialogue about your relationship, your roles, and the strengths of your particular setting, as well as areas that need to be strengthened. While the training can be completed without any CPS involvement, doing it together can create the roadmap for meaningful supervision based on what you’re both learning about each other in the training.



Each Unit of the training contains a video lesson posted on Vimeo.com along with a brief overview of the video lesson outlined in this manual (Unit Summary). The Unit Summary is included to allow people to create a group or other facilitated learning format for the training. Learning objectives are provided for each Unit. Each Unit also has exercises for the supervisor and CPS supervisee(s), as well as for the supervisor him/herself. Finally, there are readings for each Unit that are either within the manual or available through the links provided.

We hope that this curriculum provides you, the supervisor, with the information needed not only to feel competent in this new role, but to enjoy the important role of promoting the CPS field as it grows and strengthens as a valuable member of our mental health workforce.

# Table of Contents

## Part A –Introduction

### **Unit 1: Introduction to Peer Support Supervision**

Introduction

Summary

- 1.1 Supervisor/CPS exercise – Co-Learning
- 1.2 Supervisor Exercise – Recovery Orientation
- 1.3 Supervisor Exercise - Role Clarity pre-check
- 1.4 Reading – Pillars of Peer Support Supervision

## Part B – The Movement to Recovery Values and Development of a Peer Workforce

### **Unit 2: A System in Flux**

Introduction

Summary

- 2.1 Supervisor/CPS Exercise – Recovery Principles
- 2.2 Exercise –Program Self-Evaluation
- 2.3 Reading:Deegan, P. (1990). Spirit Breaking; When the helping professions hurt.
- 2.4 Reading: The President’s New Freedom Commission on Mental Health (2003).

### **Unit 3: The Birth of the CPS Profession**

Introduction

Summary

- 3.1 Supervisor/CPS exercise – Themes Part 1
- 3.2 Supervisor Exercise – Themes Part 2
- 3.3 Reflective Exercise
- 3.4 Reading: Six Fundamental Rights, Massachusetts
- 3.5 Reading: Chamberlin, Judy. A Working Definition of Empowerment.
- 3.6 Reading: Deegan, Pat. Recovery and the Conspiracy of Hope.
- 3.7 Reading: Gold, Elizabeth (2007). From Narrative Wreckage to Islands of Clarity.

# **Part C – Supervision in a Culture of Recovery**

## **Unit 4: A close Look at the CPS Training and Role**

Introduction

Summary

4.1 Supervisor/CPS exercise – CPS Code of Ethics

4.2 Supervisor Exercise – Values of Peer Support

4.3 Reading: Shery Mead, Peer Support: What Makes it Unique? (Condensed)

4.4 Reading: TRANSCOM Culture of Respect

4.5 Reading: Sample Peer Specialist Job Functions per Competencies

## **Unit 5: Supervision in the Real World**

Introduction

Summary

5.1 Supervisor/CPS exercise Role Clarity

5.2 Supervisor/CPS Exercise Integrating Peer Workers

5.3 Handout: Nuts and Bolts: Building a Job Description

5.4 Reading: Jacobson, et al., (2012) What do peer support workers do?

5.5 Reading: TRANSCOM, Culture of Respect

## **Unit 6: Avoiding the Potholes**

Introduction

Summary

6.1 Supervisor/CPS exercise – Role Confusion

6.2 Supervisor Exercise – Role Clarity

6.3 Reading – Massachusetts-Based Studies of Peer Specialists

6.4 References

# **Part D - Readings**

*Prepared by Lyn Legere, CPS, and The Transformation Center. Updated in 2016.*

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# Part A: Introduction

## Unit 1: Introduction to Peer Support Supervision

### **Learning Objectives:**

- Provide overview of the course
- Identify possible benefits of taking the course
- Distinguish between people's lived experience and worker roles
- Introduce CPS supervisor responsibilities

Please view video first

**Video Link:** <https://vimeo.com/63298198>

### **Exercises/Readings:**

- 1.1 Supervisor/CPS exercise – Co-Learning
- 1.2 Supervisor Exercise – Recovery Orientation
- 1.3 Supervisor Exercise - Role Clarity pre-check
- 1.4 Reading – Pillars of Peer Support Supervision



# Unit 1 Summary (for facilitated learning)

This summary quickly reviews the lesson presented in the Unit 1 video. This summary can be used for your own refresher or can be used to guide group learning or other facilitated learning formats with the curriculum.



Unit 1 provides an overview of the course and anchors people in the purpose and benefits of the training. As a CPS-supporting supervisor, in the training you want to be a co-learner with your supervisee(s), using dialogue rather than formal

“training.” The information offered in the training is really meant to provide the foundation upon which the “house of supervision” will be built by the individuals in the relationship.

The Introduction outlines each unit of the training and the possible benefits. Finally, this short Unit asks supervisors to think back to their first time working in their field, whether it was after graduation or during an internship, and remember the challenge of taking the classroom information to real-life application. This is meant to set the stage so supervisors can relate to the experience of newly trained CPSs. At the same time, the differences between clinical training and competencies and those of peer practice are discussed in the context of supervisory tasks. If one is to supervise another in performing his/her job, it’s necessary to understand the values and principles of the field of practice, the skills and competencies necessary for Certification, and the expectations in the work setting.



At the conclusion of the video, there is an exercise that can be done as a general discussion or, ideally, between the supervisor and CPS supervisee(s) currently working together.

# 1.1 Supervisor/CPS Exercise

## - Co-Learning

*Unit 1 provided a brief overview of the course, and discussed the importance of supervision for CPSs, many of whom have not worked in a long time. If you are already working with a CPS, have a discussion with him/her that could include some of the following talking points:*

What were your experiences during your first day or week on the job?

How did you feel about your own professional identity and strengths when you started the job?

What did the agency do to help you feel welcomed and valued during your first week on the job?

What did the agency do during your first week on the job that concerned you?

How were you supported to bring your skills and talents to the job?

How were you discouraged from bringing your skills and talents to the job?

*Be sure to let the CPS know that this is a co-learning process and these discussions will be kept confidential. If, at a later time, it seems like the information you've learned can benefit others in your organization, you should discuss this with the CPS and together decide what will be shared.*

# 1.2 Supervisor Exercise

## - Recovery Orientation

### **Welcome Process Scan**

*Most agencies have a process for all new employees. Review the process that your agency has, including any classes that new employees are required to attend, from the viewpoint of an incoming CPS or peer worker.*

1. How welcoming do these processes seem for someone who is representing a new field?

2. How relevant do these orientation processes seem for peer workers?

3. Do you see anything in the orientation process that may be difficult or isolating for peer workers or CPSs?

4. Make or advocate for changes that are needed to create a welcoming and relevant orientation process for peer workers and CPSs.

# 1.3 Supervisor Exercise - Role Clarity Checklist

Complete this checklist now as an assessment of your current knowledge base on the CPS role. You will complete it again after completing the course to see if your answers have changed.

## Agency

	Understands the role of Peer Specialist
	Values the role of Peer Specialists
	Has clarified the difference between a traditional role filled by staff with lived experience and being in a Peer Specialist Role
	Has created a clear, meaningful CPS job description
	Has fully oriented HR regarding the CPS role to enhance recruitment and retention
	Has trained HR personnel to effectively interview and hire CPSs
	Has provided in-service training for all staff on the CPS role and its values to the organization

## Supervisor

	Is experience and trained in providing supervision
	Believes in and supports the CPS workforce
	Is knowledgeable about the values and principles of peer support
	Understands the value of shared lived experience for people using services
	Is familiar with the curriculum for CPSs
	Is prepared to create a supportive environment that will support the professional growth and development of the CPS
	Is prepared to help the CPS identify strengths and areas to strengthen to grow professionally
	Is able to separate professional from personal support to avoid role confusion
	Is prepared to hold the CPS to the same professional standards expected of other staff
	Is prepared to allow the CPS the same latitude as other staff
	Understands how different employee benefits can enhance the CPS employee's performance

# Reading 1.4 Pillars of Peer Support Supervision

**This is an excerpt. For the full article See the READINGS section.**

Daniels, A. S., Tunner, T. P., Powell, I., Fricks, L., Ashenden, P., (2015) Pillars of Peer Support – VI: Peer Specialist Supervision. <http://www.pillarsofpeersupport.org>; March 2015.

The *Pillars of Peer Support Supervision* were developed at the sixth of an ongoing series of Summits, known as the *Pillars of Peer Support Services Summits*, to support the development of the peer support specialist workforce. The Pillars represent a core set of principles that are designed to guide the evolving growth of peer support services (PSS) and the workforce that provides them. The initial Pillars of Peer Support Summit was convened at the Carter Center in Atlanta, GA in 2009, and produced a founding set of 25 *Pillars of Peer Support Services*. Since then annual summits have addressed the evolving issues of funding for peer support, integration of the workforce across the continuum of behavioral health services, and the integration of these services to promote a whole-health focus. SAMHSA's Center for Mental Health Services has been an ongoing partner in this work and has actively helped promote the role of peer support services. The summary reports for each of the summits are published on the website [www.pillarsofpeersupport.org](http://www.pillarsofpeersupport.org); and also see: Daniels, Bergeson, Fricks, Ashenden, and Powell, (2012); and Grant, Daniels, Powell, Fricks, Goodale, and Bergeson (2012).

While the development of the initial set of twenty-five Pillars of Peer Support have been instrumental in fostering the evolving growth of the peer specialist workforce, an ongoing challenge has been how best to provide supervision for these services. Based on requests for guidance and support from the field, the 2014 summit was designed to address this issue. As a result, a set of pillars of supervision were developed to parallel the original pillars. A review of the evidence base for these services and the original pillars helped to establish a framework for the development of the Pillars of Peer Support Supervision.

The result of the facilitated dialogue groups was the development of a set of core principles for supervision. These concepts were then reviewed and distilled into five key themes. Based on these principles and themes, a set of five pillars were generated. Following is a detailed review of the Pillars of Peer Support Supervision, which provides the core elements of each of the

concepts and outlines the opportunities for system improvements. Many of the pillars include dual challenges for both the supervisor and the peer specialist. The focus of the pillars is to provide guidance on key components to support the peer specialist workforce, rather than to provide specific proscriptive guidance, tools, or products.

### **1) Peer Specialist Supervisors are trained in Quality Supervisory Skills**

Too often, behavioral health and social services supervisors are promoted into these roles based on their clinical experience and excellence. This does not ensure that they have had adequate training and experience in supervisory roles. Additionally when there is experience in clinical supervision, this does not necessarily transfer to similar roles in working with peer specialists. Therefore, supervisors of peer specialists should have training in both basic supervision skills, and specific skills related to supervising peer specialists.

### **2) Peer Specialist Supervisors Understand and Support the Role of the Peer Specialist**

In order to provide supervision for a peer specialist, it is vital for the supervisor to understand the key elements of their roles. Supervisors should know the job description for the peer specialist and assign tasks that are appropriate to the role and its requirements. Understanding state level certification codes and requirements helps the peer specialist supervisor address roles, ethics and professional boundaries, and fosters accountability. Goals of supervision should include helping a peer specialist supervisee understand his or her role within the agency, and fostering a collaborative relationship with the peer specialist that models collaboration for their own work with the consumers served.

The peer specialist supervisor should have a fundamental understanding of the principles of recovery and the role of peer support services in building and sustaining recovery goals. Peer specialist supervisors should be encouraged to obtain ongoing continuing education on peer support services and the recovery model. This continuing education helps the supervisor advocate for the expansion of peer specialist roles, their culture, and non-clinical orientation and roles. It also helps the supervisor to distinguish between providing support and providing therapy.

### **3) Peer Specialist Supervisors Understand and Promote Recovery in their Supervisory Roles**

The peer specialist supervisor should model the principles of recovery through their knowledge, language, and behaviors. This includes having a person-centered approach to wellness and resiliency, strength based and holistic models of service, promoting hope and empowerment, and the use of person-first language. The supervisor should encourage the peer specialist to model recovery and resiliency when sharing their story as a part of their peer support services, with the goals of instilling hope, engagement, building a trusting relationship, and encouraging skill building for those served. It is also important for the supervisor to have knowledge and awareness of the roles and contributions of the peer specialist, and to know the differences from other team member' roles. As standards of practice for peer support services evolve, and models of service fidelity continue to develop, it will be important for the supervisor to encourage and monitor adherence to them. Standards of practice have historically been generated at the state level, and new initiatives from organizations like the International Association of Peer Supporters (<https://inaops.org>) are supporting the development of national standards for this workforce. Additionally, as the services delivered by peers expand, there has been greater attention to the fidelity of service models and roles across programs. This will require continued professional development and knowledge by supervisors, as well as coinciding expansion of their roles.

#### **4) Peer Specialist Supervisors Advocate for the Peer Specialist and Peer Specialist Services Across the Organization and in the Community**

Peer specialist supervisors have a responsibility to be advocates for the role of peer support services in the organizations in which they work and in the community. This fosters a relationship of trust and support between the supervisor and supervisee. Together there is a partnership to promote the value and use of these services, and educate those in the organization and community about peer support services. Supervisors should also advocate for policies and procedures in the organization that promote and foster recovery.

#### **5) Peer Specialist Supervisors Promote both the Job Related Professional and Personal Growth of the Peer Specialist Within Established Human Resource Standards**

Peer specialist supervisors are a key link between the peer staff and the organization's leadership. In this role they have a responsibility to advocate for equal compensation and benefits for this workforce. They are also responsible for promoting professional and job related personal growth. This can include access to training and continuing education, evolving peer specialist role opportunities, and appropriate career ladders. Personal growth may include maintaining a safe work environment, personal wellness, and individual goal attainment. A collaborative supervisory relationship is supportive, provides timely and respectful feedback, and is strength based.

# **Part B - The Movement to Recovery Values and Development of a Peer Workforce**

## **Unit 2: A System in Flux**

Unit 2 concerns the realities of our mental health system as it attempts to shift from a “care-taker” model to one that fosters and encourages growth, recovery, resiliency and self-determination.

## **Unit 3: The Birth of the CPS Profession**

Unit 3 focuses on the relationship between our current CPS Profession and the “consumer/survivor/ ex-patient’s” movement of the past.



## Unit 2: A System in Flux

### Learning Objectives:

- Describe “maintenance” and “recovery-oriented” system models
- Identify components related to system change
- Describe the impact of “learned helplessness” in relation to “maintenance-based” systems
- Identify core findings of Presidential New Freedom Report
- Identify challenges to supervision in colliding worlds

Please view video first

**Video Link:** <https://vimeo.com/63940280>

### Exercises/Readings:

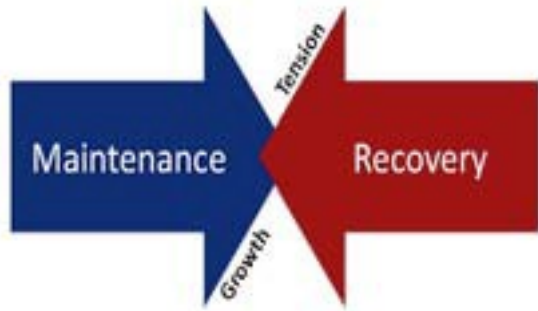
2.1 Supervisor/CPS Exercise – Recovery Principles

2.2 Exercise –Program Self-Evaluation

2.3 Reading: Deegan, P. (1990). Spirit Breaking; When the helping professions hurt.

2.4 Reading: The President’s New Freedom Commission on Mental Health (2003). Achieving the Promise: Transforming mental health care in America. Final report, Executive Summary.

# Unit 2 Summary (for facilitated learning)



Unit 2 concerns the realities of our mental health system as it attempts to shift from a “care-taker” model to one that fosters and encourages growth, recovery, resiliency and self-determination. Its goal is to provide a framework that doesn’t assess blame on any individual or organization, but instead

helps everyone see what’s been accomplished and where challenges continue to exist. It’s meant to recognize that big systemic change cannot happen overnight.

Pat Deegan’s “Spirit Breaking: When the helping professions hurt” is one of the readings for this Unit, and artfully paints this picture. (Supervisors should be told that the language in the article is dated, but the concepts are just as meaningful today).



This Unit then introduces the Presidential New Freedom Report of 2003 that recommended a “transformation” of the mental health system, believing it wasn’t possible to fix the system by little repairs here and there.

It argued that the only way to fix the mental health system was to radically change the focus (to recovery), the outcomes (to living, learning, working and participating fully in the community) and the orientation (to a person- and family-driven system).

The unit then introduces SAMHSA's recovery components, discussing each component and its importance, and ends with the recognition that there is inherent conflict between the two systems, and that, in this time of flux, those conflicts remain.



# Supervisor/CPS Exercise 2.1

## - Recovery Principles

*SAMHSA's Working Definition of Recovery includes 10 Components of Recovery. People in recovery responded that HOPE comes before everything else. SAMHSA listened and moved hope to the beginning of the list.*

The previous 10 Components have been revised, updated, and in some cases replaced and are now called the 10 Guiding Principles of Recovery...

- 1. Recovery emerges from Hope**
- 2. Recovery is Person-Driven**
- 3. Recovery occurs via Many Pathways**
- 4. Recovery is Holistic**
- 5. Recovery is supported by Peers and Allies**
- 6. Recovery is supported through Relationship and Social Networks**
- 7. Recovery is Culturally-based and -influenced**
- 8. Recovery is supported by Addressing Trauma**
- 9. Recovery involves Individual, Family and Community Strengths and Responsibilities**
- 10. Recovery is based on Respect**

# Supervisor/CPS Exercise 2.1

## - Recovery Principles

*Unit 2 has discussed the conflict between "recovery" and "maintenance" mental health delivery systems. Most organizations are somewhere between being a "maintenance-based" and being a "recovery-oriented" agency. It may be that some pockets of the agency have been able to shift more easily than others, that ideas have been able to change more easily than practices, or that desires have changed more quickly than needed resources.*

SAMHSA's Guiding Principles to Recovery are below

1. You and your CPS supervisee(s) independently review the guiding principles.
2. Each of you (independently) ranks each component as follows:
  - S - a strong component of your overall agency approach
  - I - Incomplete, or a component that is present, but not throughout the agency
  - A - Absent, or a component that hasn't been incorporated in agency approaches at this point.
3. Compare your ratings and discuss the areas that were different. What did each of you base your rating on? Why did you rate it the way you did? (The goal is the discussion, rather than having one person change their rating to match the other's).
4. What steps could you take individually or together to begin to make changes in areas that are either incomplete or absent at this time?

# Supervisor/CPS Exercise 2.2

## - Program Self-Evaluation

*A program self-evaluation is attached below. Both you, the supervisor, and your CPS supervisee(s) should complete the self-evaluation and then compare ratings.*

1. About what areas did you agree?
2. What areas did you rate differently?
3. Do these differences fall within a certain theme or area of practice?
4. Do you see major differences in your scoring in any specific area or throughout the assessment?
5. If “yes” to number 4, does this seem like a functional or philosophical difference – that is, a difference in what can be done or what should be done within the provision of services?
6. How do these differences impact the work being done at your organization?
7. How do these differences impact your supervisor/supervisee relationship?
8. What steps can you take to work through the differences?

# Program Self-Evaluation

**Directions:** The following outlines specific competency areas and associated skills. Review each area and rate how frequently you demonstrate the **items** listed. Respond to each item based on how frequently you perform the behavior (how often you actually put the skill into actual practice). For example: identify if you Always, Frequently, Occasionally, Sometimes, or Rarely/Never use person first language and behavior to promote recovery. You are encouraged to answer as honestly as possible. After you have responded to all items, use the **Self-Evaluation** to identify your areas of strength and training and mentoring or coaching needs.

Rating Frequency of Performance 5 = Always, 4 = Frequently, 3 = Occasionally, 2 = Sometimes, 1 = rarely or Never					
<b>Area 1: Person–Oriented Attitudes, Values, Knowledge and Behavior</b>					
5	4	3	2	1	
					“Person first” language and behavior is used to promote dignity and respect.
					Links to self-help activities are provided by all staff to promote self-reliance.
					All personnel recognize that recovery is not necessarily about a “cure,” but is about achieving a meaningful and satisfying life.
					Recovery is defined as a process and outcome within the service system.
					The agency identifies personal, program level and system level barriers to recovery.
					The agency creates conditions and environments so individuals can access knowledge, supports and skills that enhance recovery.
					Staff recognizes that disclosure of personal lived experience by all staff members is valuable.
					The belief that everyone has the potential to recover, grow and change is a core philosophy of services.
					Agency staff believes that people can recover and make their own treatment and life choices.
					Staff recognizes and works to address stigma and discrimination.
					Staff understands the role of non-clinical professionals, including peer workers, Certified Peer Specialists, Employment Specialists, etc., and offer these services to all people using services.
					Staff recognizes the negative impact of psychiatric diagnoses and support people to reconceptualize wellness vs. distress.
					Policies of the agency ensure that there is a balance between duty of care and support for people to take positive risks and make the most of new opportunities.
					Services support people in maintaining and developing meaningful social, recreational, occupational and vocational activities, which enhance mental wellbeing.
					Staff actively assists people in recovery with the development of career and life goals that go beyond symptom management and stabilization.

**Strength-Based Recovery Planning**

5 = Always, 4 = Frequently, 3 = Occasionally, 2 = Sometimes, 1 = rarely or Never

5	4	3	2	1	
					Strength-based assessments, including the dimensions of wellness (physical, spiritual, emotional, occupational, social, intellectual, environmental), are conducted.
					The person's natural support system is used to assist in assessment and individualized recovery planning.
					Discussions supporting people incorporate past and present skills, resources, interests, values, emotional distress and useful interventions, to identify their chosen goals in living, learning, working and social settings.
					People using services are exposed to recovery through integration of peer workers throughout the agency.
					People's feeling of readiness for change is explored and developed in domains of living, learning, working and participating in social activities.
					Staff and people using services collaborate to set observable and measurable objectives.
					Staff recognizes the importance of lived experience in inspiring hope and belief in recovery, and all staff is supported to disclose their own lived experience.
					Staff understands that a recovery-oriented system involves a redistribution of power in relationships, and is able to join into collaborative partnerships with people receiving services.



**Support Strategies**

5 = Always, 4 = Frequently, 3 = Occasionally, 2 = Sometimes, 1 = rarely or Never

5	4	3	2	1	
					All staff members form positive relationships and partnerships with people using services based on empathy and trust.
					Staff assists people in identifying, selecting and designing their own overall goals related to living, learning, working and social roles.
					Services teach, model and reinforce relevant skills necessary for success in living, learning, working and social environments.
					All staff support and promote opportunities to enhance a person's positive social connections with family, children, friends and their valued community.
					Staff understands and is able to implement effective and trauma-informed crisis prevention and intervention strategies.
					People using services are made aware of and supported in using Wellness and Recovery Action Plans (WRAP) or other self-help strategies that promote self-responsibility and help prepare for, and/or prevent, relapse and crisis.
					Relevant strategies are based upon individual wants and needs rather than cookie-cutter interventions.
					Services reflect an understanding of the interdependent nature of wellness dimensions (physical, spiritual, emotional, occupational, social, intellectual, environmental, financial).
					Services reflect sensitivity to the impact of trauma on persons in recovery.
					Staff links people with sources of information of interest to them, including resource directories, internet searching, and clearing house information.
					All staff members advocate for access to services and systems change.
					Staff understands eligibility criteria and referral procedures to access social services, leisure and adult learning opportunities.
					People in recovery can choose and change, if desired, the therapist, psychiatrist, or other service provider with whom they work.
					Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.
					The agency provides a variety of treatment options (i.e., individual, group, peer support, holistic healing, alternative treatments, medical) from which agency participants may choose.
					Staff plays a primary role in helping people in recovery to become involved in non-mental health/addiction related activities, such as church groups, special interest groups, and adult education.

## Reading 2.3, Deegan, P., “Spirit Breaking.....”

Deegan, Patricia: Spirit Breaking: When the Helping Professions Hurt  
by Patricia Deegan, Ph.D.

As published in The Humanistic Psychologist

Volume 18(3), pp. 301-313

Autumn 1990

**This is an excerpt. For the full article See the READINGS section.**

### **Abstract**

Too often the human services dehumanize and depersonalize those who come to receive services, as well as those professionals who provide physical disabilities and people with psychiatric disabilities are frequently hurt by helping professionals, the phenomenon of “spirit breaking” is introduced. Suggestions for re-humanizing the human services are made. Including new models for clinical interaction that serve to empower rather than disempower service recipients, and the contributions that people with psychiatric disabilities are making in their own state and national movements for social justice and the right to humane treatment and rehabilitation services.

Recently I was asked to speak with a group of graduate students in clinical psychology. In preparing my talk I reflected on what the most important message was I could share with these young people who would soon enter professional practice. The message I felt called to share was rather simple: People with disabilities are people. When we forget that people with psychiatric disabilities share a common humanity with us then the human is stripped from human services and the stage is set for the emergence of the inhuman and the inhumane. The inhuman and the inhumane emerge from that rupture which occurs when one human being fails to recognize and reverence the humanity and the fundamental sanctity, sovereignty and dignity of another person. Such a rupture in mutual relatedness occurs often in the helping professions and for this reason, helping professionals sometimes hurt rather than help people with disabilities. Too often the human services dehumanize and depersonalize. Many people with disabilities refer to this special kind of hurt as “spirit breaking,” or “how the system tries to break your spirit.” I think we can all learn from the paper I shared with those graduate students. It went like this: Being a student is very important work. Beyond merely mastering a finite content area of study and becoming proficient in clinical practice, we also have the obligation to develop and articulate our values and the ideals, which form the foundation of our clinical praxis. We must take the latter aspect of our work very seriously, because when we leave the university setting and enter the day-to-day business of clinical psychology it is very easy to become compromised in our values and ideals. It is easy to lose sight of our humanity as the common ground we share with those who come to use

for help. When we make the transition from being a student to being a professional clinician, our culture and human service institutions grant us a broad range of power over the lives of people who are in distress. With that power comes enormous responsibility and great risk. Our responsibility is to never lose sight of the fundamental sanctity, dignity and sovereignty of another human being no matter what their diagnosis may be, no matter how "regressed" or "poor" their prognosis may be and no matter what their disability may be. The risk is that the power which is granted and which we also assume as clinicians, can begin to eat away at our values and ideals such that we fail to safeguard and uphold the fundamental sanctity, dignity and sovereignty of those whom we seek to serve. The danger is that we can over identify with the professional roles we play and forget the people we are. The danger is that our minds can become severed from our hearts such that our no longer guide, inform or shape our work with people.

**For the full article See the READINGS section.**

# Reading 2.4, Presidential New Freedom Report

<http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/downloads.html>



The President's New Freedom  
Commission On Mental Health

Parklawn Building, 5600 Fishers Lane, Suite 13C-26, Rockville, Maryland 20857  
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July 22, 2003

Dear Mr. President:

On April 29, 2002, you announced the creation of the New Freedom Commission on Mental Health, and declared, "Our country must make a commitment. Americans with mental illness deserve our understanding and they deserve excellent care." You charged the Commission to study the mental health service delivery system, and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities. We have completed the task. Today, we submit our final report, *Achieving the Promise: Transforming Mental Health Care in America*.

After a year of study, and after reviewing research and testimony, the Commission finds that recovery from mental illness is now a real possibility. The promise of the New Freedom Initiative—a life in the community for everyone—can be realized. Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.

The time has long passed for yet another piecemeal approach to mental health reform. Instead, the Commission recommends a fundamental transformation of the Nation's approach to mental health care. This transformation must ensure that mental health services and supports actively facilitate recovery, and build resilience to face life's challenges. Too often, today's system simply manages symptoms and accepts long-term disability. Building on the principles of the New Freedom Initiative, the recommendations we propose can improve the lives of millions of our fellow citizens now living with mental illnesses. The benefits will be felt across America in families, communities, schools, and workplaces.

The members of the Commission are gratified by your invitation to serve, are the innovative programs across America that we learned about, and are impressed with the readiness for change that we find in the mental health community. We look forward to the work ahead to make recovery from mental illness the expected outcome from a transformed system of care.

Sincerely,

A handwritten signature in black ink, appearing to read "M F Hogan", written in a cursive style.

Michael F. Hogan, Ph.D.  
Chairman, President's New Freedom Commission on Mental Health

The Commission members:

Jane Adams, Ph.D.  
Rodolfo Arrendondo, Jr., Ed.D.  
Patricia Carlile  
Charles G. Curie, M.A., A.C.S.W.  
Daniel B. Fisher, M.D., Ph.D.  
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Nancy C. Speck, Ph.D.  
The Honorable Randolph J. Townsend, M.Ed.  
Deanna F. Yates, Ph.D.

# Unit 2, References

Deegan, P. (1990) Spirit Breaking; When the helping professions hurt, *The Humanistic Psychologist*, 18(3), pp. 301-313

DHHS Pub. No. SMA-03-3832. Rockville, MD: U.S. Department of Health and Human Services. Presidential New Freedom Report, Executive Summary (2003)

SAMHSA's Working Definition of Recovery

<http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF>

# Unit 3: The Birth of the CPS Profession

## Learning Objectives:

- Describe the history of the “Peer” or “Consumer/Survivor/Ex-Patient’s” Movement
- Describe the core values underlying peer-to-peer practice
- Describe the beginnings of peer practice in Massachusetts
- Distinguish the peer support worker and Certified Peer Specialist role
- Provide an overview of CPS competencies

Please view video first

**Video Link:** <https://vimeo.com/64078963>

## Exercises/Readings:

- 3.1 Supervisor/CPS exercise – Themes Part 1
- 3.2 Supervisor Exercise – Themes Part 2
- 3.3 Reflective Exercise
- 3.4 Reading: Six Fundamental Rights, Massachusetts
- 3.5 Reading: Chamberlin, Judy. A Working Definition of Empowerment.
- 3.6 Reading: Deegan, Pat. Recovery and the Conspiracy of Hope.
- 3.7 Reading: Gold, Elizabeth (2007). From Narrative Wreckage to Islands of Clarity.

## Links:

- 3.8 Reading: Baseman, R. (2006). The Evolution from Advocacy to Self-Determination.  
<http://store.samhsa.gov/shin/content/SMA06-4195/SMA06-4195.pdf> Chapter 4, pp 14-22.
- 3.9 Reading: Clifford Beers Monograph (2009).  
<http://www.human-spirit-initiative.org/blog2/stories-2/clifford-beers/>
- 3.10 Reading: Cullen-DuPont, Kathryn (2002). Packard v. Packard.  
<http://www.encyclopedia.com/doc/1G2-3498200080.html>

# Unit 3 Summary (for facilitated learning)

## The Birth of the CPS Profession

Unit 3 focuses on the relationship between our current CPS Profession and the “consumer/survivor/ex-patient’s” movement of the past. It discusses key people from the past, like Clifford Beers, John Henry Perceval and Elizabeth Packard, with respect to their going public about their experiences within the mental health system.



These people’s stories, the rationale for writing them, and the actions that came forth because of them are related to the core practice of using lived experience by today’s CPSs to inspire hope and facilitate change. The module also describes the roles of CPS and Peer Support Workers, and distinguishes the two roles, as well as describing the original intention to have both roles in the state. It also discusses difficulties in having only the CPS role.



This unit uses the stories and activities of the highlighted to explain how the mantra “Nothing About Us Without Us” came to be and its continued importance in CPS and peer worker roles and function in the mental health system.

This unit also highlights people from Massachusetts in “The Movement,” including Pat Deegan, Isaiah Uliss, Deborah and John Delman and Steve Holochuck. It uses educational and activism activities in the state to demonstrate the “change agent” role of CPSs.

**NOTHING  
ABOUT US  
WITHOUT US**

This unit also provides an overview of Massachusetts’ efforts since 1990 to create paid positions for people with lived experience: DMH Office of Consumer Affairs headed by Steve Holochuck, the Consumer



Provider Program, Peer Debriefers, CPSs on PACT teams, the Recovery Educators project through MBHP and, finally, the CPS class in 2006 and dedicated CPS roles in the state.

Finally, this unit links the historical threads to the core competencies that are incorporated in the Massachusetts Certified Peer Specialist training course, with an emphasis on sharing lived experience, working from a place of mutuality, and healing through relationship.

## 3.1 Supervisor/CPS Exercise - Themes Part 1

In looking at the history of the C/S/X or peer movement, certain themes were repeated that have worked their way into current peer practice:

- Freedom from oppression
- Freedom from discrimination
- Re-instating and affirming rights
- Self-help
- Self-determination
- Choices beyond the medical model
- Alternative views of emotional distress
- Education through auto-biography
- Being a change agent
- Empowerment
- Nothing About Us Without Us

Discuss these themes with your CPS supervisee(s).

1. How are each of these themes brought into the practices at your organization, and especially into peer practice?
2. In what ways could practices be changed or improved to strengthen these components in your services?

## 3.2 Supervisor Exercise - Themes Part 2

*Most of the items outlined in Exercise 3.1 are thematic. The items that you evaluated in the Program Self-Evaluation (Exercise 2.2) are much more concrete, relating to specific tasks or service orientation of the organization.*

1. Consider how each of the themes listed below relate to the items in Sections Program Self-Evaluation. (This can be done as a reflective exercise over time, a written exercise item by item, or a discussion between yourself and other staff and/or CPS supervisee(s). The goal is to think through how each of these plays out in agency practice, rather than to complete a written assignment in a set period of time.)

- Freedom from oppression
- Freedom from discrimination
- Re-instating and affirming rights
- Self-help
- Self-determination
- Choices beyond the medical model
- Alternative views of emotional distress
- Education through auto-biography
- Being a change agent
- Empowerment
- Nothing About Us Without Us

## 3.3 Reflective Exercise

*This reflective exercise is meant as a way for you to integrate the information from the training into your work. If you'd like to correspond with the author about your reflections, questions, etc. please feel free to do so.*

1. How does connecting CPS work to the core principles and values of the peer and recovery movement enhance our mental health system?
  
2. Think about some of the other civil rights movements that you are aware of (racial civil rights of the 1960's-70's, the gay rights movement, etc.). Reflect on ways that participation in "the movement" impacted individuals (rather than on the wider, social impact of the movement).
  
3. How can you, as a supervisor, carry and use this information in your direct supervision, in your conversations with others that work on the same team or department, and in any policy decisions in which you may be involved regarding peer work and the agency as a whole?

## 3.4 Reading, The Six Fundamental Rights

(Massachusetts)

**(Massachusetts General Laws, Chapter  
123, Section 23)**

Any person hospitalized in a psychiatric unit licensed by the Department of Mental Health (this includes all private psychiatric hospitals) or state hospitals, or living in DMH or DMH-licensed residential facilities, shall have the following rights:

### **Fundamental Right #1:**

(a) reasonable access to a telephone to make and receive confidential telephone calls and to assistance when desired and necessary to implement such right; provided, that such calls do not constitute a criminal act or represent an unreasonable infringement of another person's right to make and receive telephone calls.

#### **Violations include:**

- No phones are available on psychiatric units.
- Patients aren't allowed to make calls, no matter how important.
- Only pay phones are available, and a reasonable source of money or assistance to make calls is not provided.
- Telephones are located in hallways or common rooms.
- Telephones are located adjacent to/next to nursing stations, so staff members can hear your conversations.
- Staff listens to phone calls.
- Telephones are shut off for unreasonably long periods of time.

### **Fundamental Right #2:**

(b) The right to send and receive sealed, unopened, uncensored mail. Writing materials and stamps in reasonable quantities shall be available for use, and assistance should be provided in writing, addressing and posting letters.

#### **Violations include:**

- You aren't allowed to send mail or open mail addressed to you, without it being inspected by staff, unless there is "good cause" to do so, and the inspection is ordered by administrators. Good cause is defined as suspected transmission of contraband materials ONLY.
- Mail (incoming or outgoing) is read by staff.
- Writing implements, paper, and a reasonable amount of postage to write letters are not provided.

### **Fundamental Right #3:**

(c) The right to receive visitors of your own choosing daily and in private, at reasonable times.

**Violations include:**

- You aren't provided with a private and unmonitored space to meet with visitors.
- Visits are restricted to public areas (i.e., kitchen, dining room, dayroom, hallway, etc.)
- Staff is present or monitoring visits, so they can overhear conversations with visitors.
- You can't refuse visits from people you don't wish to see.
- Visiting hours are limited to one to two hours a day, or non-consecutive one-hour periods.
- Visiting hours are short and the hospital is in a remote location.

**Fundamental Right #4:**

(d) The right to have a humane psychological and physical environment. Each person shall have accommodations which allow them privacy and security in resting, sleeping, dressing, bathing, toileting, and personal hygiene, as well as reading and writing.

**Violations include:**

- Denial of a safe and reasonably private environment for resting and sleeping.
- Observation by staff while bathing, using the bathroom, or dressing/undressing.
- Being placed, especially in residential facilities, with roommates who trigger you or endanger your own health.
- Staff insensitivity to trauma issues.

**Fundamental Right #5:**

(e) The right to receive or refuse to receive visits and telephone calls from your attorney or legal advocate, physician, psychologist, clergy member or social worker, at any reasonable time.

**Violations include:**

- Not being allowed to meet with an attorney, legal advocate, doctor, psychologist, clergy member or social worker or not allowed to meet at a reasonable time.
- No flexibility around scheduling such meetings (i.e., visits aren't allowed beyond regular visiting hours.
- Upon admission, you are not given the name, address, and telephone number of a free legal service.
- No clear understanding of who valid legal representatives are.
- A list of legal advocates is not posted or provided upon request.

**Fundamental Right #6:**

(f) reasonable daily access to the outdoors, as weather conditions reasonably permit, at inpatient facilities in a manner consistent with the person's clinical condition and safety as determined by the treating clinician and with the ability of the facility to safely provide access. The department shall promulgate regulations defining what shall constitute reasonable access and regulations implementing sufficient precautions to ensure the safety of staff members charged with accompanying patients outdoors.

### **Additional Provisions of the law:**

Any dispute or disagreement concerning the exercise of the aforementioned rights in clauses (a) to (f), inclusive, and the reasons therefor shall be documented with specific facts in the client's record and subject to timely appeal.

Any right set forth in clauses (a), (c) or (f) may be temporarily suspended, but only for a person in an inpatient facility and only by the superintendent, director, acting superintendent or acting director of such facility upon such person; concluding, pursuant to standards and procedures set forth in department regulations that, based on experience of such person's exercise of such right, further such exercise of it in the immediate future would present a substantial risk of serious harm to such person or others and that less restrictive alternatives have either been tried and failed or would be futile to attempt. The suspension shall last no longer than the time necessary to prevent the harm and its imposition shall be documented with specific facts in such person's record.

A notice of the rights provided in this section shall be posted in appropriate and conspicuous places in the program or facility and shall be available to any such person upon request. The notice shall be in language understandable by such persons and translated for any such person who cannot read or understand English.

In addition to the rights specified above and any other rights guaranteed by law, a mentally ill person in the care of the department shall have the following legal and civil rights: to wear his own clothes, to keep and use his own personal possessions including toilet articles, to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases, to have access to individual storage space for his private use, to refuse shock treatment, to refuse lobotomy, and any other rights specified in the regulations of the department; provided, however, that any of these rights may be denied for good cause by the superintendent or his designee and a statement of the reasons for any such denial entered into the treatment record of such person.

## 3.5 Reading, A Working Definition of Empowerment

**This is an excerpt. For the full article See the READINGS section.**

*By Judi Chamberlin*

"Empowerment" has become a popular term in mental health programs, yet it has lacked a clear definition. In a research project designed to measure empowerment in programs funded by and for mental health services users, we first undertook to come up with a working definition. Key elements of empowerment were identified, including access to information, ability to make choices, assertiveness, and self-esteem. Empowerment has both an individual and a group dimension. Details of the definition are provided, along with a discussion of the implications of empowerment for psychiatric rehabilitation programs.

EMPOWERMENT: The Elements:

- **Having decision-making power.**
- **Having access to information and resources.**
- **Having a range of options from which to make choices.**
- **Assertiveness.**
- **A feeling that the individual can make a difference.**
- **Learning to think critically; unlearning the conditioning; seeing things differently.**
- **Learning about and expressing anger.**
- **Not feeling alone; feeling part of a group.**
- **Understanding that people have rights.**
- **Effecting change in one's life and one's community.**
- **Learning skills that the individual defines as important.**
- **Changing others' perceptions of one's competency and capacity to act.**
- **Coming out of the closet.**
- **Growth and change that is never ending and self-initiated.**
- **Increasing one's positive self-image and overcoming stigma.**



## 3.6 Reading

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*To inquire about use please contact pat@patdeegan.com*

# Recovery, Rehabilitation and the Conspiracy of Hope

*by Patricia E. Deegan, Ph.D.*

**This is an excerpt. For the full article See the READINGS section.**

I would like to thank you for this opportunity to speak with you today. Recently I had the opportunity to go to Australia to deliver a keynote address. The theme of that conference was: “There is a person in here”. I really liked that conference theme. There is a person in here: this is such a simple statement yet it is so profound. In many respects coming to know that there is a person in *here* is the easy part. Remembering to always listen for and to reverence the person over *there* - that can be the more difficult part. In any case I would like to share that paper with you.

I believe it is a spirit of hope that gathers us here together today. We are direct service workers and administrators, policy makers and family members, service users and mental health professionals. Fifteen years ago you would never have caught us all in the same room together! Indeed, ten years ago we would hardly even speak to each other! But here we are, gathered together - social workers sitting next to family members who are sitting next to policy makers, who are sitting next to casemanagers, who are sitting next to academicians who are sitting next to service users . . . What is going on here? Are the old rules being broken? Is the old order shaking a bit at the foundation? IS THERE A CONSPIRACY GOING ON?

I love the word conspiracy. It comes from the Latin “conspirare” which means to breath the spirit together. What is the spirit we are breathing together here today?

It is a spirit of hope. Both individually and collectively we have refused to succumb to the images of despair that so often are associated with mental illness. We are a conspiracy of hope and we are pressing back against the strong tide of oppression which for centuries has been the legacy of those of us who are labeled with mental illness. We are refusing to reduce human beings to illnesses. We recognize that within each one of us there is a person and that, as people, we share a common humanity with those who have been diagnosed with mental illness. We are here to witness that people who have been diagnosed with mental illness are not things, are not objects to be acted upon, are not animals or subhuman life forms. We share in the certainty that people labeled with mental illness are first and above all, human beings. Our lives are precious and are of infinite value.

## 3.7 Reading, From narrative wreckage to islands of clarity: stories of recovery from psychosis, Elisabeth Gold

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1949240/>

Can Fam Physician. Aug 2007; 53(8): 1271–1275.  
PMCID: PMC1949240

**This is an excerpt. For the full article See the READINGS section.**

### **Stories of recovery from psychosis**

Psychosis involves a combination of an individual’s unique genetic, neurologic, psychological, and environmental factors. The course varies widely and fluctuates, often with cycles of remission and relapse. Recent research indicates that about two thirds of those affected will recover or substantially improve with treatment (which includes both medication and psychosocial approaches).

Recovery is an arduous biological, psychological, social, and spiritual journey—a gradual process of restoring connections and health. It is a personal process of growth and change that typically embraces hope, autonomy, and affiliation as elements of establishing satisfying and productive lives in spite of disabling conditions and experiences.

Significant recovery is a real possibility. Recovery is a natural process that can occur gently in a sane, healthy environment and can be fostered through authentic relationships. ... Recovery is facilitated only when a genuine sense of friendship is fostered among caring people, both staff and clients. Recovery requires community. A healing community is one that promotes the well-being of each of its members.

## Unit 3 References

Massachusetts General Laws, Ch. 123, S. 23, Five Fundamental Rights,  
<http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter123/Section23>

Baseman, R. (2006) The evolution from advocacy to self-determination. In Center for Mental Health Services. Mental Health, United States, 2004. Manderscheid, R.W., and Berry, J.T., eds. DHHS Pub no. (SMA)-06-4195. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

Chamberlin, J. (1997) A working definition of empowerment. J. Psychiatric Rehabilitation, 20(4), 43-46.

Deegan, P. (1996) Recovery and the Conspiracy of Hope. Presentation, September 16, 1996 "There's a Person In Here": The Sixth Annual Mental Health Services Conference of Australia and New Zealand. Brisbane, Australia.

Gold, Elizabeth (2007) From Narrative Wreckage to Island of Clarity, Canadian Family Physician, 53. 1271-1275  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1949240/>

Human Spirit Initiative (2009), Clifford Beers Monograph,  
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Cullen-DuPont, Kathryn (2002), Packard v. Packard,  
<http://www.encyclopedia.com/doc/1G2-3498200080.html>

# Part C - Supervision in a Culture of Recovery

## Unit 4: A close look at the CPS training and role

Unit 4 provides an overview of the CPS course, what skills and abilities people need to be successful in the course, what the course covers and how the material presented in the course relates to practice in the real world.

## Unit 5: Supervision in the Real World

Four areas above and beyond typical supervision duties are described as key supervisor tasks that contribute to successful CPS practice.

## Unit 6: Avoiding the Potholes

The final unit of the training addresses some known “potholes” that can derail the process of successfully integrating CPSs into traditional mental health settings.

# Unit 4: A close look at the CPS Training and Role

## Learning Objectives:

- Describe “pre-requisites” for the CPS Training Course (skills needed to be successful)
- Identify Three CPS Core Competencies
- Describe major themes and requirements under the CPS Code of Ethics
- Relate the CPS Code of Ethics to CPS job tasks
- Identify job tasks that are consistent and inconsistent with CPS Training

Please view the video first

**Video Link:** <https://vimeo.com/64082012>

## Exercises/Readings:

- 4.1 Supervisor/CPS exercise – CPS Code of Ethics
- 4.2 Supervisor Exercise – Values of Peer Support
- 4.3 Reading: Shery Mead, Peer Support: What Makes it Unique? (Condensed)
- 4.4 Reading: TRANSCOM Culture of Respect
- 4.5 Reading: Sample Peer Specialist Job Functions per Competencies

# Unit 4 Summary (for facilitated learning)

## The CPS Training Course and Job Description

Unit 4 provides an overview of the CPS course, what skills and abilities people need to be successful in the course, what the course covers and how the modules presented in the course relate to practice in the real world.

The unit begins by describing the “pre-requisites” for the course, including the ability to utilize peer support, brainstorm solutions, initiate self-care, and have basic knowledge of recovery-oriented, trauma-informed environments and peer practices.

The unit describes each of the modules, beginning with the Code of Ethics. It describes ethical prohibitions regarding sexual relationships, taking gifts and money, etc. as well as cautions regarding dual relationships. At the same time, it discusses the reality of complex relationships, and outlines the rationale for more flexible boundaries. It also describes the requirement that CPSs self-disclose and support self-determination, with special note that these requirements preclude CPSs from serving as representative payees or medication managers. (Performing these tasks also conflicts with the mutuality of the role.)



The next modules overviewed relate to sharing one’s recovery story. Different types and uses of recovery stories, especially snippets, is described with an example to demonstrate what this might look like in a real setting and how it can be valuable.

“Partnering” modules are reviewed, with an emphasis on how CPSs support people to find their own inner wisdom, rather than step in to advise or tell people what they should do. This reinforces the CPS requirement to support self-determination, and also demonstrates ways that CPSs do this.

The unit also describes the framework of recovery taught in the course with an emphasis on how recovery is viewed in this model as a process of reframing self-image and belief in one’s possibility in life, rather than anything to do with symptom management.

The unit describes the module on human experience language in greater detail than most as this can be an area of particular conflict for CPSs entering the traditional workforce. Understanding the relationship of language to beliefs and/or language and the messages we send, even inadvertently, is important for anyone who’s supporting peer workers.

The two primary areas this unit discusses in relation to language are: negative messages about people who have mental health diagnoses; and communicating myths and untruths about the causes, interventions and prognosis related to emotional distress and extreme states, more commonly termed “mental illness.”



Many terms related to mental health practice are laden with disrespect, dehumanization, and diminish the very essence and spirit of the person using services. Terms like “manipulative” or “Borderline” are two that are particularly pejorative.



As research widens our knowledge about myriad factors that contribute to, cause and mediate emotional distress, maintaining language that describes only one understanding – “mental illness” – can impact hope-inspiring environments, a core piece of recovery-oriented practice. In addition, such language eliminates exploration of other factors, such as a history of trauma that may be the real cause of the distress experienced by the individual.

The unit explains how CPSs are taught to use ‘human experience language’ not to tell others what to think, but to open the door for all possibilities rather than just the medical model.

The unit also briefly describes tools and strategies. It then goes on to describe myths and misconceptions related to peer practice.<sup>1</sup> Finally, it ends with further discussion about self-determination, a repeated theme throughout. It describes the concept of “learned/taught helplessness,” along with the CPS goal of supporting people, through constant appeal to self-determination, to move from “taught helplessness” to “taught capability.”



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# Supervisor/CPS Exercise 4.1

## - The CPS Code of Ethics

### CPS Code of Ethics

The CPS Code of Ethics is attached below.

1. Review the Code of Ethics.
  
2. Meet with your CPS supervisee(s). For each ethical requirement in the Code of Ethics:
  - a) Discuss the meaning of the ethical requirement (the CPS supervisee should have a copy of the CPS Training module that describes each ethic).
  
  - b) Each of you should describe specific tasks that the CPS does that meet this ethical requirement.
  
  - c) Ask the CPS to describe any conflicts or difficulties the CPS experiences in adhering or maximizing this ethical requirement.

# **Certified Peer Specialists Code of Ethics Massachusetts**

*Written and approved by the Georgia Mental Health Consumer Network for the State of Georgia Certified Peer Specialist Training Program – Revised and Updated by members of the Massachusetts Consumer Operated Programs & Activities leadership in 2006. Further revisions were done in the summer of 2008 and summer of 2013, and 2015 based on survey and other feedback from the field.*

Certified Peer Specialists represent a new role, dedicated to using knowledge, skills, and personal experience to support others. Like all professions, Certified Peer Specialists have a Code of Ethics. Simply stated, a code of ethics is a set of principles created by a group (profession) to provide guidelines for the ethical behavior of its members.

*"Why have a Code of Ethics?"*

There are many reasons for having a Code of Ethics. One key reason is that it makes the expectations very concrete and clear. While we all may think we have a pretty good sense of what is morally “right,” the reality is that what you think is “right” and what I think is “right” may differ. So, we look to the Code of Ethics:

- To define accepted/acceptable behaviors;
- To promote high standards of practice;
- To provide a benchmark for CPS’s to use for self-evaluation;
- To establish a framework for professional behavior and responsibility; and
- Occupational identity

After we discuss the Code of Ethics, you will be asked to sign it as a public declaration of your commitment to follow them during the class, in your relationship with your new colleagues, and in your future professional work.

The following principles will guide Certified Peer Specialists in the various roles, relationships, and levels of responsibility in which they function. These expectations also apply to training participants with respect to interactions with their colleagues.

## **In other words, your professional CPS life starts today !**

1. The primary responsibility of Certified Peer Specialists is to help people achieve what they want most in life, their own goals, needs and wants. Certified Peer Specialists will be guided by the principles of self-determination for all.
2. Certified Peer Specialists will maintain high standards of personal conduct. Certified Peer Specialists will also conduct themselves in a manner that fosters their own recovery and integrity.
3. Certified Peer Specialists will openly share their recovery stories, and will likewise be able to identify and describe the supports that promote their recovery.
4. Certified Peer Specialists will, at all times, respect the rights and dignity of the people with whom they work.
5. Certified Peer Specialists will never intimidate, threaten, harass, use undue influence, physical force, or verbal abuse, or make unwarranted promises of benefits to the individuals with whom they work

6. Certified Peer Specialists recognize that everyone is different and we all have something to learn from one another. Therefore, Certified Peer Specialists will not practice, condone, facilitate or collaborate in any form of discrimination on the basis of ethnicity, race, gender, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical disability, or any other preference or personal characteristic, condition or state.
7. Certified Peer Specialists will advocate as a partner with those they support that they may make their own decisions in all matters when dealing with other professionals.
8. Certified Peer Specialists will respect the privacy and confidentiality of those they support.
9. Certified Peer Specialists will advocate for the full integration of individuals into the communities of their choice and will promote the inherent value of these individuals to those communities. Certified Peer Specialists will be directed by the knowledge that all people have the right to live in the least restrictive and least intrusive environment of their choice.
10. Certified Peer Specialists will not enter into dual relationships or commitments that conflict with the interests of those they support.
11. Certified Peer Specialists will never engage in sexual/intimate activities with those to whom they are currently providing support, or have worked with in a professional role in the past year.
12. Certified Peer Specialists will keep current with emerging knowledge relevant to recovery, and openly share this knowledge with the people with whom they work.
13. Certified Peer Specialists will not engage in business, extend or receive loans, or accept gifts of significant value from those they support.
14. Certified Peer Specialists will not offer support to another when under the influence of alcohol or when impaired by any substance, whether or not it is prescribed.

***I \_\_\_\_\_ fully understand the Code of Ethics and commit myself to carrying out the fourteen principles listed above during my CPS training, and on becoming Certified and obtaining a role as a Certified Peer Specialist.***

***Signature \_\_\_\_\_ Date: \_\_\_\_\_***

# Supervisor Exercise 4.2

## - Values of Peer Support

1. Read the Shery Mead article, "Peer Support: What Makes it Unique?" (Reading 4.3 Condensed version attached)
  
3. Consider the following questions:
  - a) How is peer support utilized in your agency?
  - b) Is this consistent with the core values of "peer support?"
  - c) Are there ways that you, as a supervisor, can impact practices in your agency to strengthen peer support practice?

## 4.3 Reading: Peer Support: What Makes It Unique?

Shery Mead, Peer Support: What Makes it Unique?

<http://www.intentionalpeersupport.org/wp-content/uploads/2014/04/Peer-Support-What-Makes-It-Unique.pdf> (Full Version)

**This is an excerpt. For the full article See the READINGS section.**

Abstract (Dec. 2004)

Peer support in mental health has recently gained significant attention. There is increasing talk about funding and credentialing, standards and outcomes. But what is peer support and how is it different than services, even services delivered by people who identify themselves as peers? In this paper we would like to present a perspective on peer support that defines its difference and also maintains its integrity to the movement from which it came. We will offer some thinking about practice and evaluation standards that may help different types of peer initiatives sustain real peer support values in action.

Shery Mead is the past director of three New Hampshire Peer Support Programs including a peer run hospital alternative. She has done extensive speaking and training, nationally and internationally, on the topics of alternative approaches to crisis, trauma informed peer services, systems change, and the development and implementation of peer operated services. Her publications include academic articles, training manuals and a new book co-authored with Mary Ellen Copeland, Wellness Recovery Action Planning and Peer Support. Shery's current interests include: developing a theory and practice base for peer operated programs, de-pathologizing the effects of trauma and abuse, and finding research and evaluation models that accurately reflect the work of peer programs.

Cheryl MacNeil, PhD is an Assistant professor at the Sage Colleges. She is concerned with the role of research and evaluation in promoting issues of social justice and democracy. Cheryl has served as an evaluation consultant with a variety of organizations including studies conducted with the New York Association of Psychiatric Rehabilitation Services, Sweetser Health, Northeastern Blue Shield, and the NYS Office of Mental Health. She is also a founding resident of the Pottery District, a neighborhood alliance in Troy, New York. She is a believer in and contributor to the renaissance of Troy, New York. Her primary teaching responsibilities at the Sage Colleges include research design and community occupational therapy practice.

## 4.4 Reading Transcom -

### ***PROMOTING A CULTURE OF RESPECT***

#### ***Transcom's Position Statement on Employee Self-Disclosure in Health and Social Service Workplaces***

As members of the Massachusetts Transformation Committee (Transcom), we support the vision of a statewide network of activities and services driven by the wisdom and needs of people with mental health, addiction and trauma-related challenges. We believe that when people share their personal stories, it is inspiring, builds relationships, and gives new meaning and value to painful experiences. Personal accounts and research confirm that as more peer workers are integrated into treatment settings, outcomes improve. When people are in an active relationship with those who have faced similar challenges, both parties are more able to sustain their efforts at recovery, professional development, healing and personal growth.

#### **TRANSCOM'S COMMITMENT**

While recognizing that this perspective might be new for many, we endorse workplaces and policies that view voluntary, personal disclosure within the context of helping relationships in a positive light. Transcom is committed to the ongoing development of respectful interactions within all work environments. We look forward to a time when the disclosure of mental health, addiction and trauma-related diagnoses by an employee is not associated with negative consequences such as shame and discrimination.

#### **OUR PURPOSE**

This statement is intended to encourage organizations to fully support and value all staff that wish to share from their diverse life experiences. By promoting responsible and open exchange, we hope to inspire inclusion and a culture of respect for people with all types of difficulties, not only within the health and social service workforce, but also within society as a whole.

An open environment where personal struggles are shared is necessary to the success of peer workers, who, by definition, disclose that they live meaningful lives with mental health, substance use and trauma-related challenges. The success of this new workforce is particularly vital at a time when a limited understanding of the skills, values and expertise of peer workers threaten the integrity of Certified Peer Specialists and other peer worker roles.

We are encouraged by the leadership of organizations who have worked with these issues and who support and recruit employees who disclose a variety of challenges and diagnosis. We hope that this statement stimulates energetic dialogue in every workplace about policies and practices related to personal disclosure.

## **THE WORKFORCE OF PEOPLE IN RECOVERY**

We honor the strength and resilience of peer support pioneers in the workforce. Pioneers include peer workers who were the first to work in the system and workers in other roles who were the first to disclose in their organizations. Many of these leaders continue to contribute to more inclusive, open, and empowering work environments.

Many individuals in the workforce have lived experiences of recovery from a variety of circumstances and many do not feel comfortable or welcome to share their expertise. We recognize that agency leaders are at various stages of awareness about the benefits and responsibilities of a work culture which values the recovery experience of people who have dealt with mental health, addiction and trauma-related challenges. Advocating for the support of personal disclosure means confronting long-standing practice standards that advise against personal sharing; practices and principles which are still promoted by many organizations and professional schools.

## **INTEGRITY OF THE PEER WORKFORCE**

Education and experience with the recovery model and the impact of sharing personal information is essential for disclosure to be effective. The number of people who are trained and guided by the Certified Peer Specialist Code of Ethics does not meet the demand for CPS services. While disclosure by other behavioral health professionals can be developed as a resource, it is not accurate to assume that disclosure by professionals trained in traditional models of care is adequate for implementing recovery-oriented practices. Personal sharing by staff trained in traditional models of care is not a substitute for the work of peer providers.

## **LOOKING FORWARD**

Disclosure by employees of a mental health, addiction or trauma related experience can be a complicated issue at every point in the service system, including for those who provide and use services, supervisors and funders as well as teachers and students in professional training programs. The sharing of human difficulties by staff helps to create a system where these experiences are not seen solely as those of “clients”. As with any communication in the workplace, we expect that decisions about disclosure will be considered thoughtfully and be based foremost on the needs of the people who are using services. In all cases, we expect that self-disclosure will continue to be a choice that is personal and voluntary.

*Original statement endorsed February 23, 2007*

*Revised statement endorsed unanimously by members of Transcom*

*April 26, 2013*

## 4.5 Reading, Sample Job Functions

**Change Agent /Recovery Agent** With the understanding that the CPS is not antagonistic towards the system, but invested in positive change, the expectation of the core competency of *Change Agent* is that the CPS works towards system improvement, whether that be in small or subtle ways or as an outspoken advocate for revised policies and practices. The CPS is collaborative and facilitative, serving as a catalyst for change, with a full appreciation of the concept of catalyst as someone whose presence alone can precipitate change.

- Using one's personal story and experience as a primary tool, the CPS will:
  - Facilitate the transition from a professionally-directed treatment plan to self-developed and self-directed personal recovery plan
  - Offer living proof of the transformative power of recovery
- Provide stage-appropriate education about recovery
- Support recovery orientated approaches in behavioral health services
- Provide information as to the purpose of peer support and recovery models
- Assist non-consumer staff in identifying program environments that are conducive to recovery
- lend their unique insight into experiences of living with a psychiatric diagnosis, and what makes recovery possible.
- Attend treatment team meetings to promote consumer's use of self-directed recovery tools.
- Partner with co-workers to enhance the team's understanding of the perspectives of people in recovery and to identify/promote the use of recovery-oriented practices by having open dialogues.
- Encourage self-advocacy and economic self-sufficiency
- Support people and those intimately involved with them how to navigate complex service systems
- Inform non-peer staff, the community, and potential service users about the prevalence, pathways, and styles of long-term recovery
- Develop and expand access to recovery support resources
- encourage activities across religious, spiritual, and secular frameworks that enhance life meaning and purpose
- Model and educate about recovery to people using and people providing services
- Provide and advocate for effective recovery based services.
- Assist people in obtaining services that suit that person's recovery needs within or beyond the agency
- Inform people about community and natural supports and how to use these in the recovery process
- demonstrate faith in the capacity for change, and encourage and celebrate recovery achievements
- Model effective coping techniques and self-help strategies.
- Providing and advocating for effective recovery based services.
- Cultivate a dialogue and disseminate information regarding educational and vocational opportunities within the community as part of the recovery process

*Continued on next page*



## Sample responsibility statements

**Being “In” but not “Of” the System** – Often misunderstood, the core competency of *In but not Of the System* refers to the tension inherent in the role of the CPS. People working in CPS roles are working “in” the system, in the sense that they are paid by the system, collaborating to provide services within a team or program, and bound to follow employer policies and relevant regulations. In a perfect world, the mental health system would be recovery-oriented and guided by the principle of self-determination, rather than repairing deficits, managing symptoms, and avoiding risk. However, even in this ideal situation, disagreements might arise between service providers (the “system”) and service users. The CPS, being “in but not of,” can take a position solidly as allied with the person using services. This is not to say that the CPS is against the system, but, rather, serves in a role that blends the functions of translator, advocate, mediator, negotiator, ombudsman, and educator.

*Relevant to PACT, CBFS, ESP, RLC, Day Treatment, Inpatient, Outpatient CPSs*

- Support people to access and connect to natural supports. I.e. Recovery Learning Community, Peer meetings, Dual Recovery and Community Meetings.
- Create network systems for people with other peers, peer run organizations and the community at large.
- Teach and role model the value of everyone's recovery experience.
- Assist people in obtaining services that suit that person's recovery needs, even if the choice is at a different agency.
- Assist consumers in developing empowerment skill through self-advocacy and stigma-busting.
- Facilitate a dialogue and create a knowledge base among people using services to help them to be actively involved in their treatment.
- Assisting people in regaining the ability to make independent choices and to take a proactive role in treatment including discussing questions or concerns about medications, diagnoses or treatment approaches with their treating clinician
- Mobilize internal and external recovery resources
- Help resolve environmental obstacles to recovery
- Process peoples' response to professional services, mutual support and self-help
- Introduce “newcomers” into the local culture of recovery
- Provides an orientation to recovery roles, rules, rituals, language, and etiquette
- Create opportunities for broader community participation
- Enhance cooperative relationships between professional service organizations and indigenous recovery support groups
- Cultivates opportunities for people in recovery to participate in volunteerism and other acts of service to the community),

# Unit 4: References

*Massachusetts Certified Peer Specialist Code of Ethics*, CPS Training Program,  
© Appalachian Consulting Group and The Transformation Center

Legere, L. and Nemec, P. (2011). *Sample Peer Specialist Job Functions per Competencies*. Presented at "Nuts and Bolts of Peer Support," Austin, TX.

Mead, S. and McNeil, C. (2004). *What Makes Peer Support Unique*  
<http://www.intentionalpeersupport.org/wp-content/uploads/2014/04/Peer-Support-What-Makes-It-Unique.pdf>

New Zealand Government, *Power of Peer Support*.  
<https://www.mentalhealth.org.nz/assets/ResourceFinder/MHC-power-of-peer-support-services.pdf>

# Unit 5: Supervision in a Culture of Recovery

## **Learning Objectives:**

- Describe importance of supervision
- Identify the core functions of any supervision
- Describe assumptions of supervisor experience and focus on Unit
- Describe a “welcoming environment” and its importance

Please view the video first

**Video Link:** <https://vimeo.com/64216463>

## **Exercises/Readings:**

- 5.1 Supervisor/CPS exercise Role Clarity
- 5.2 Supervisor/CPS Exercise Integrating Peer Workers
- 5.3 Handout: Nuts and Bolts: Building a Job Description
- 5.4 Reading: Jacobson, et al., (2012) What do peer support workers do?
- 5.5 Reading: TRANSCOM, Culture of Respect

# Unit 5 Summary: (For Facilitated Learning)

Unit 5 brings the process of individual supervision, and secondary related roles. The Unit begins by reminding people of the importance of supervision in ensuring quality care, but also a satisfied workforce.

Four areas above and beyond typical supervision duties are described as key supervisor tasks that contribute to successful CPS practice: role clarity (job description); ensuring a welcoming environment; providing advocacy when needed; and offering “recovery oriented” supervision.

Developing a job description is critical because of the newness of the position and lack of clarity by many about what the role is and the tasks that should be performed by the CPS. Creating a meaningful, descriptive job outline lets everyone know what’s expected and provides an objective way for both the CPS and the supervisor to evaluate how well the person is performing in their job. It also is a way to constantly remind people that CPSs are employees and not looked at as “former clients”.

## **NORMATIVE**

Management tasks related to the organizational needs.

## **FORMATIVE**

Support professional competency and growth.

## **RESTORATIVE**

Attend to work-related stress through encouragement, coaching, etc.

Peer Recovery Specialist	
<b>Job Tasks</b>	<b>Job Function</b>
Use Active Listening Support Decision Making Strategize options to explore and gather information needed for decision making and setting goals	
<b>Job Description</b>	

Function: Support recovery and resiliency on the individual and system level through mutual healing relationships, sharing lived experience of recovery and self-help

The second key supervisor task described in “ensuring a welcoming environment.” This addresses the need to make sure that others on the team or who work with the CPS are also on board, understanding the role and function of the position, and having had time to discuss any prejudices or biases they have about people with lived experience working side-by-side as colleagues.

The third supervisory task or role is to be thoughtful in analyzing “equal treatment” of employees, recognizing that identical treatment is not always equal treatment. As the potential “newcomer” in a system that has many rules and

traditions – a culture, if you will – of medically based treatment approaches, the lone CPS may achieve greater equality when allowed to access work resources outside the setting than be told to rely on resources within that are not consistent with their profession or role. A good supervisor will take the time



to analyze situations to reach a fundamentally fair decision rather than default on the assumption that identical treatment is equal treatment.

Finally, the concept of “recovery oriented” supervision is recommended. This doesn’t mean taking on the role in the CPSs recovery, but instead, using the values of a recovery oriented system in supervision. This is something we should be doing across the board as our systems are as much in recovery as people using services. Using the values of strengths-based assessment, keeping the bar up, expecting success, focusing on skills and supports, and offering ways for people to improve their functioning in their role is good policy for all supervision.

# Supervisor/CPS Exercise 5.1 - Role Clarity

*This exercise gives you the opportunity to evaluate your job description. If you are working with a CPS supervisee(s), you can do this together. If not, you can do this on your own.*

1. Does your job description have a summary statement that describes the primary purpose of the position in your agency? If not, draft a summary that matches your expectations of the role (you may want to do this after completing # \_\_\_\_ below.)

The Certified Peer Specialist will \_\_\_\_\_

2. Does the job description include 4-6 main areas of work that a CPS will perform? If not, write them below (see examples in the Job Description Handout)

Primary Functions of the CPS Position include:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

3. Does the job description include specific skills and abilities related to the functions of the CPS that can be objectively measured and evaluated? If not, outline them below.

4. Having gone through this exercise, have you created the parts of a job description that can provide guidance to your CPS supervisee(s)? If not, add in anything below that can support your CPS supervisee(s).

5. Have you created a job description (or at least the components) that is meaningful to you as the supervisor? If not, add in anything below that can support you as a supervisor.

6. Are all tasks described in your job description consistent with CPS training and Code of Ethics? If not, make any needed adjustments.

## 5.2 Reading, CPS Job Description

### The Job Description

A job description provides a summary of the primary duties, responsibilities, and qualifications of a position. It is important to reflect priorities and current expectations.

#### Components of the job description:

##### *Function:*

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

##### *Reporting Relationships*

Describe the “chain of command” and the types of supervision the employee will get and will give, indicating the specific job titles of the supervisors and the positions supervised.

##### *Responsibilities*

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

##### *Qualifications/Competencies*

List required and preferred qualifications, credentials, and competencies in order of importance.

These might include educational requirements (e.g., a high school diploma or equivalency), training or certification as a peer specialist, or specify that the employee must be a person in recovery (e.g. “Be a self-identified current or former user of mental health or co-occurring services who can relate to others who are now using those services” or “Must be a self-disclosed individual with a mental illness)

*Note: Texas requirements for Medicaid reimbursement require that a peer provider must have received a high school diploma or a high school equivalency certificate; have at least one cumulative year of receiving mental health services for a disorder that is treated in the target population for Texas; and be under the direct clinical supervision of a Licensed Professional of the Healing Arts (LPHA).*

*-From the Texas Certified Peer Specialist Learning Community Implementation Toolkit (Via Hope).*

##### *Employment Conditions*

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

##### *Tips from the Small Business Association (<http://www.sba.gov>):*

- A good job description begins with a careful analysis of the important facts about a job, such as tasks involved, methods used to complete the tasks, and the relationship of the job to other jobs.
- It’s important to make a job description practical by keeping it dynamic, functional, and current.
- Don’t get stuck with an inflexible job description! A poor job description will keep you and your employees from trying anything new and learning how to perform their job more productively. A well-written, practical job description will help you avoid hearing a refusal to carry out a relevant assignment because “it



## **Sample Peer Specialist Job Description Components\***

### Sample function statements

- Provide vision driven hope and encouragement support people in their recovery and assist them in connecting to the community
- Provides opportunities for individuals receiving services to direct their own recovery process (self-determination) and by acting as an advocate for the needs and rights of persons served
- Works with individuals in groups and on a one-to-one basis to provide recovery training and outreach to individuals who use mental health services in the community
- Shares personal recovery experiences and develops authentic peer-to-peer relationships
- Offers instruction and support to help people develop the skills they need to facilitate their individual recovery
- Informs people served of available service options and choices while promoting the use of natural supports and resources within the community
- Provides peer mentoring and support for individuals with psychiatric disabilities and receiving mental health services
- Assists individuals in navigating the mental health services system and in achieving resiliency and recovery as defined by the person

### Sample responsibility statements

- Assist in the orientation process for persons who are new to receiving mental health and/or co-occurring disorders services
- Educate and engage individuals in the Wellness Recovery Action Plan process as a means to recognize early triggers and signs of relapse, and use of individual coping strategies as an alternative to more restrictive services
- Outreach/accompany to ensure the individual is making a successful transition to community integration and is continuing their progress toward recovery goals
- Support the individual in seeking to connect/reconnect with family, friends, significant others and in learning how to improve or eliminate unhealthy relationships
- Provide education and advocacy within the community that promotes awareness of psychiatric disorders while reducing misconceptions, prejudice, and discrimination
- Keep treatment team informed about individual's strengths, accomplishments and obstacles in relation to their recovery goals
- Complete all required documentation in a timely, legible manner
- Educate professional staff about the recovery process and the damaging role that stigma can play in undermining recovery
- Visit community resources with people using services to assist them in becoming familiar with potential opportunities
- Facilitate (via personal coaching and WRAP groups) the transition from a professionally directed service plan to a self-directed Recovery Plan
- Model personal responsibility, self-advocacy, and hopefulness through telling one's personal recovery story, how needs are respectfully met, and how a belief in oneself is maintained
- Ensures confidentiality of individual information
- Assess emergency situations, notifies supervisor and/or appropriate clinical and administrative personnel of actual or potential problems
- Exhibits a nonjudgmental approach, effective listening, good eye contact, and positive interactions

Other:

## Sample Position (Job) Description

### **Key Functions and Responsibilities (Key Tasks)**

- *Assist peers in choosing, obtaining and keeping wellness and healthy lifestyle related goals.*
- *Help a peer work through the process of identifying health and wellness related goals.*
- *Ask facilitative questions to help peers gain insight into their own personal situations.*
- *Empower peers to find solutions for health problems and concerns they are facing.*
- *Help peers to find their own solutions by asking questions that give them insight into their wellness status.*
- *Assist in identifying steps to take to achieve a health and wellness related goal.*
- *Assist peers in strengthening their readiness to actively pursue health wellness.*
- *Use a variety of methods, tailored to the individual, to move through the process of setting and reaching health and wellness related goals.*
- *Provide structure and support to promote personal progress and accountability.*
- *Compile and share wellness and healthy lifestyle resources for peers and other staff or supporters.*
- *Selectively use self disclosure to inspire and support.*

\*adapted from job descriptions and materials from Pennsylvania, North Carolina, Recovery Innovations of Arizona, Florida Peer Network Inc., the Transformation Center (Boston, MA), and Collaborative Support Programs of NJ

## 5.3 Reading

# What do peer support workers do? A job description

Nora Jacobson, Lucy Trojanowski and Carolyn S Dewa

<http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-205>

**This is an excerpt. For the full article See the READINGS section.**

The percentages of time spent doing direct and indirect work in both inpatient and outpatient settings are shown in Tables 1 and 2.

**Table 1**

**Percentage of time spent on different direct activities**

Type of Activity*	mean%	minutes per day/person**
Advocacy	16.3%	33.6
Connecting to resources	36.9	78.4
Experiential sharing	68.3	153.2
Building community	33.4	80.5
Relationship building	65.3	149.3
Group facilitation	14.1	28.6
Skill building /mentoring/goal setting	38.8	79.6
Socializing/self-esteem building	63.9	142.7
Other	8.3	14.6

**Table 2**

**Percentage of time spent on different indirect activities**

Type of Activity*	mean %	minutes per day/person**
Group planning and development	15.4%	25.0
Administration	27.2	40.0
Team communication	24.3	40.5
Supervision/training	8.3	13.6
Receiving support	10.8	24.6
Education/awareness building	10.4	23.2
Information gathering and verification	16.8	38.2
Other	11.3	20.5

## **Conclusions**

Appropriate job descriptions are essential to the success of the job incumbent because they help to ensure that the recruitment and selection process is executed effectively and that the best candidate is selected for the job. They also guide the goals and activities of the incumbent once he or she is hired. The findings of this evaluation led us to propose a general peer job description that may be useful to organizations seeking to develop peer support programming. A successful peer will have qualifications beyond having had experience with mental health and/or addiction problems. A relevant job description should specify the other types of skills and experiences that characterize a well-qualified and effective candidate. In this way, it can help facilitate the integration of peers into their multi-disciplinary work teams and add legitimacy to the work of peers.

## 5.5 References

Jacobson, N., Trojanowski, L., and Dewa, C. (2012) What do peer support workers do? A job description. BMC Health Services Research  
<http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-205>

Legere, L and Nemec, P (2011). The CPS Job Description. For presentation at Via Hope, 2011. <http://www.viahope.org/resources/peer-specialist-job-description-overview>

# Unit 6: Avoiding the Potholes

## **Learning Objectives:**

- Identify 5 concerns (myths) frequently expressed by staff
- Describe accurate correction for each myth
- Describe role confusion
- Identify three (3) strategies to ensure role clarity

Please View video first

**Video Link:** <https://vimeo.com/64097515>

## **Exercises/Readings:**

- 6.1 Supervisor/CPS exercise – Role Confusion
- 6.2 Supervisor Exercise – Role Clarity
- 6.3 Reading – Massachusetts-Based Studies of Peer Specialists
- 6.4 References

# Unit 6 Summary: (For Facilitated Learning)

Unit 6, the final unit of the training, addresses some known “potholes” that can derail the process of successfully integrating CPSs into traditional mental health settings.



The module begins by reviewing common staff concerns about the role of peer specialist (typically when the first few CPSs begin working at the agency.) Recognizing the concerns and addressing them in a timely manner can help avoid simmering issues that, over time, can be destructive to working relationships between CPSs and

other more established staff

The specific concerns addressed include staff beliefs around the “fragility” of peer staff, their ability to perform administrative tasks, and if they will be able to maintain confidentiality and appropriate boundaries. Finally, staff often believe that having CPSs and peer workers will add to their work burden, not lessen it.

Each of these concerns is individually addressed, but more important, supervisors are recommended to take the time to have these important conversations with team staff prior to having peer workers join the staff. Similarly, sharing the job description and making sure that everyone is on the same page regarding the tasks and responsibilities that are and are not part of the CPSs position.



Another potential “pothole” highlighted is what is called “role confusion.” This refers to confusion between current employer/employee/colleague relationships and former service provider/service user relationships. This is an especially

strong possibility when the CPS has received services at the specific agency at which he or she is working, but can also happen when the individuals now working as colleagues were never in a service user/provider relationship. The fact that one employee is a CPS automatically opens the door to this possibility.



Many CPSs have reported how supervisors have interpreted their dissatisfaction with work situations as “symptoms” rather than genuine feelings. Similarly, supervisors have often reported how difficult it is to refrain from inquiring about the employee’s mental health and self-care beyond usual supervisee concerns.

Guidance is offered to avoid potholes related to role confusion.

Finally, the Unit quickly summarizes what was covered throughout the entire course, and hopes that the training will positively benefit supervision practices.



# Supervisor/CPS Exercise 6.1 - Role Confusion

## Role Confusion Exercise

Instructions: Read through each scenario and indicate what your best answer would be. After going through the scenarios, go to the second set of instructions after questions 5.

1. Your CPS supervisee comes to you and says that she's having a hard time doing her job. She's experiencing a lot of anxiety, she says, so when she has to meet with people in neighborhoods she's not familiar with, she has panic attacks. This has led her to miss appointments with people she's working with, and then feel guilty about it. She doesn't know what to do. In response, you....
  - a. Ask her what she's been doing to deal with her panic attacks, including finding out if she's gone to see her psychiatrist to check on her medication or see if alternative medication might be more helpful.
  - b. Suggest that she might be able to get some accommodations under the ADA, and refer her to the human resource department.
  - c. Ask her what she thinks might be helpful to manage her job requirements, including meeting with people in neighborhoods that she's not familiar with.
  
2. You've been supervising a CPS for about 6 months, and he's been a great asset to the department. His work has been excellent and the people using services really like him a lot. Over the past few weeks, however, you've noticed a change. He seems to have lost his spark, seems irritable and unenthusiastic about his work. Other staff members have also commented on the changes and fear he is beginning to relapse. As his supervisor, you decide to...
  - a. Set up a meeting with him to check in with him and see if he's experiencing and increase in symptoms.
  - b. Set up a meeting with him to let him know you've noticed that he doesn't seem like his usual self, and you just wanted to check in.
  - c. Leave it alone. If he needs to let you know anything, it's up to him to bring it to you.
  
3. You've hired a CPS, and she's been working with you for about three months. She's a really nice woman who tries hard and is clearly committed to her work. At the same time, she doesn't seem to grasp the work. You've reviewed her job description with her a couple of times, and authorized some supervision with a CPS that doesn't work at the agency. None of these efforts seem to be having any effect on her job performance. You know her probation period is coming to an end, and are considering...
  - a. Letting her go for poor job performance;
  - b. Extending her probationary period, given that she's new to her job and, having

- a mental illness, probably needs more time to adjust to the job;
  - c. Keep her on, but change her work away from direct services to supporting the clinical team by bringing people to the grocery stores and other rote errands that have to get done.
4. You've been supervising a CPS for quite awhile. She's a great worker, and you really value her work. You know, from your meetings with her, that she's really been struggling with depression and is considering taking a medical leave. As is appropriate, you've been supporting her to weigh and balance this decision, and connect with HR personnel to determine what company benefits can support her if she does take a leave. On this particular day, however, she sounds particularly stressed, and you're concerned about her. You decide you should:
- a. Get the name of her emergency contact from HR and call that person to share your concern;
  - b. Ask her for the name of her therapist so you can call her.
  - c. Ask her if she'd like some support to call her therapist or someone else who can give her some support.
  - d. Ask her if you can support her in some way
  - e. Tell her you're concerned, and hope she's getting some support.
5. Your CPS supervisee comes to you in distress because he's having a hard time figuring out his SSDI/SSI benefits in relationship to work. He's gone to the HR department and been told that they only deal with retirement issues with Social Security. He says he doesn't understand this, and feels like this is discriminatory against people who are specifically required to have a disability to get the job. You...
- a. Agree with HR – this is an issue specific to peoples' disability, not employment, and they should find resources beyond the workplace for this support.
  - b. Agree that this seems like different treatment, and agree to look into it.
  - c. Agree to advocate that the organization either hire personnel with this expertise or contract with and pay for consultant services to meet the employee needs.

Instructions 2: Go through each scenario again, but replace "CPS" with another colleague. For example, in the first scenario, instead of "Your CPS supervisee..." think of "Your social worker supervisee..." or "Mary, your supervisee."

Did your answers change at all?

What led you to change your answers?

What did you learn about yourself from this exercise?

Instructions 3: Ask your CPS supervisee to go through the scenarios and tell you what his/her answers might be and why.

(See next page for suggested answers)

1. Your CPS supervisee comes to you and says that she's having a hard time doing her job. She's experiencing a lot of anxiety, she says, so when she has to meet with people in neighborhoods she's not familiar with, she has panic attacks. This has led her to miss appointments with people she's working with, and then feel guilty about it. She doesn't know what to do. In response, you....
  - a. Ask her what she's been doing to deal with her panic attacks, including finding out if she's gone to see her psychiatrist to check on her medication or see if alternative medication might be more helpful.
  - b. Suggest that she might be able to get some accommodations under the ADA, and refer her to the human resource department.
  - c. Ask her what she thinks might be helpful to manage her job requirements, including meeting with people in neighborhoods that she's not familiar with.

Both B and C might apply to this scenario. Depending on the number of CPSs and the design of the services, there may be the possibility of a reasonable accommodation that doesn't impact the essential functions of the job. It could be that, for a set period of time, the person can go to new places the first time with a fellow CPS, and also be building some skills in the meantime. If there weren't any possibility for job restructuring, temporarily or permanently, then "C" would be the answer.

2. You've been supervising a CPS for about 6 months, and he's been a great asset to the department. His work has been excellent and the people using services really like him a lot. Over the past few weeks, however, you've noticed a change. He seems to have lost his spunk, seems irritable and unenthusiastic about his work. Other staff members have also commented on the changes and fear he is beginning to relapse. As his supervisor, you decide to...
  - a. Set up a meeting with him to check in with him and see if he's experiencing an increase in symptoms.
  - b. Set up a meeting with him to let him know you've noticed that he doesn't seem like his usual self, and you just wanted to check in.
  - c. Leave it alone. If he needs to let you know anything, it's up to him to bring it to you.

It's fitting to check in with him, especially given that other staff are bringing it to your attention. You want to keep the focus primarily on work, but checking in when you see someone is having a hard time is something that you'd probably do with anyone.

3. You've hired a CPS, and she's been working with you for about three months. She's a really nice woman who tries hard and is clearly committed to her work. At the same time, she doesn't seem to grasp the work. You've reviewed her job description with her a couple of times, and authorized some supervision with a CPS that doesn't work at the agency. None of these efforts seem to be having any effect on her job performance. You know her probation period is coming to an end, and are considering...
  - a. Letting her go for poor job performance;
  - b. Extending her probationary period, given that she's new to her job and,

- having a mental illness, probably needs more time to adjust to the job;
- c. Keep her on, but change her work away from direct services to supporting the clinical team by bringing people to the grocery stores and other rote errands that have to get done.

Just like every other profession, CPS is not a job for everyone. Even if someone passed the exam, it may turn out that the job isn't a good fit for his or her skills and abilities. Extending the probationary period would make sense if the person was showing steady improvement, but not in this situation.

Moving someone to a different job, especially a menial job, is hurtful and harmful on a number of levels: it perpetuates the message that "those sick people can't really do the work," and avoids the more difficult conversations about job performance and needing to let someone go if they can't do the work. And for the individual, it can be far more devastating than losing a job and realizing it's not a good match for them (whether immediately or after time to think it through.)

4. You've been supervising a CPS for quite awhile. She's a great worker, and you really value her work. You know, from your meetings with her, she's really been struggling with depression and is considering taking a medical leave. As is appropriate, you've been supporting her to weigh and balance this decision, and connect with the HR personnel to determine what company benefits can support her if she does take a leave. On this particular day, however, she sounds particularly stressed, and you're concerned about her. You decide you should:
  - a. Get the name of the emergency contact from HR and call that person to share your concern;
  - b. Ask her for the name of her therapist so you can call her.
  - c. Ask her if she'd like some support to call her therapist or someone else who can give her some support.
  - d. Ask her if you can support her in some way.
  - e. Tell her you're concerned, and hope she's getting support.

The last choice is the best because it keeps the employee in charge of how much to share about his/her private life. This is the type of situation that pulls on the 'care-taker' strings and the relationship of provider-client. This is your employee, not a service user, so you should not be intervening in any way. If you have a strong supervisory relationship, this one comment can be an invitation for the person to share more, but the choice remains with the employee.

5. Your CPS supervisee comes to you in distress because he's having a hard time figuring out his SSDI/SSI benefits in relationship to work. He's gone to the HR department and been told that they only deal with retirement issues with Social Security. He says he doesn't understand this, and feels like this is discriminatory against people who are specifically required to have a disability to get the job. You...
  - a. Agree with HR – this is an issue specific to peoples' disability, not employment, and they should find resources beyond the workplace for this support.

- b. Agree that this seems like different treatment, and agree to look into it.
- c. Agree to advocate that the organization either hire personnel with this expertise or contract with or pay consultant services to meet the employee needs.

For the most part, Human Resources deals with the benefits that are relevant to their employees. Medicare retirement isn't an employer-offered benefit, but was probably added to the HR menu because there were many employees needing information on this as they were retiring. SSDI and SSI are similarly a benefit that is of central concern to CPS employees as they begin or expand their work responsibilities. The question always becomes, "is it equal or unequal?"

## 6.2 Exercise - Role Clarity Checklist

You completed this checklist in the introductory unit. Please go over it again and reflect upon any changes you notice in relation to better understanding the CPS role and your role as a CPS supervisor.

### Agency

	Understands the role of Peer Specialist
	Values the role of Peer Specialists
	Has clarified the difference between a traditional role filled by staff with lived experience and being in a Peer Specialist Role
	Has created a clear, meaningful CPS job description
	Has fully oriented HR regarding the CPS role to enhance recruitment and retention
	Has trained HR personnel to effectively interview and hire CPSs
	Has provided in-service training for all staff on the CPS role and its values to the organization

### Supervisor

	Is experience and trained in providing supervision
	Believes in and supports the CPS workforce
	Is knowledgeable about the values and principles of peer support
	Understands the value of shared lived experience for people using services
	Is familiar with the curriculum for CPSs
	Is prepared to create a supportive environment that will support the professional growth and development of the CPS
	Is prepared to help the CPS identify strengths and areas to strengthen to grow professionally
	Is able to separate professional from personal support to avoid role confusion
	Is prepared to hold the CPS to the same professional standards expected of other staff
	Is prepared to allow the CPS the same latitude as other staff
	Understands how different employee benefits can enhance the CPS employee's performance

## 6.3 Reading

### Massachusetts-Based Studies of Peer Specialists

Several studies have examined the role of peer specialists in Massachusetts mental health services. DMH's 2010 electronic survey gathered feedback about the experiences, size and the nature of the state's peer workforce. Research by the Center for Health Policy and Research at UMass Medical School in 2000 examined the factors that facilitate and hinder peer specialist from fulfilling their role. Over the past three years, Transcom has also gathered information, through less formal means, about how the integration of peer workers is experienced by key people using and providing mental health services. Panel discussions were held with representatives from four groups: peer specialists working in a range of programs, managers and supervisors at agencies where peers are working, Recovery Learning Community staff and people who have worked with peer specialists over the course of their recovery.

**The DMH study** gathered data from 24 provider organizations and DMH offices and from 64 individual peer workers using Survey Monkey. It concludes, in part:

Throughout the survey responses, there was evidence of provider organizations taking positive steps toward hiring, integrating, and supporting a peer workforce and of peer workers that are daily using their experience to empower the people they serve and to produce positive changes in their organizations.

At the same time, some peer workers continue to feel isolated, unsupported and undervalued in their roles and nearly half of peer workers identify some situations in which they are confronted with insensitive or disrespectful interactions. The voice of the peer worker was powerful in expressing the successes and challenges that they face and their words were frequently used in the report. It is evident from this small sample that providers are at different points in the process of defining, hiring and integrating a peer workforce and some appear to be experiencing more success than others. **Training of non-peer staff and addressing organizational culture when it conflicts with fully embracing a peer workforce were among the strongest themes in the survey results** [emphasis ours] and there is significant opportunity to work with providers and peer workers on this ongoing need. In addition, these ongoing challenges further confirm the need for ongoing support of the peer workforce. Most providers identified an interest in additional training, support, and technical assistance, highlighting both the need and opportunity for improvement.

The complete 14-page report can be found on the Mass DMH website:

<http://www.mass.gov/eohhs/researcher/behavioral-health/mental-health/dmh-results-and-reports.html>

**In the UMASS study**, both peer and non-peer workers were interviewed about the factors that impacted the work of peer specialists. Most of those identified were related to how agencies prepared for the integration of peer workers and how they oriented established workers and peer specialists to each other. These concerns and topics reflect the fact that the peer specialist role is new in many programs. This study identified the following factors that facilitated the integration of peer specialists:

Support from higher management

- Supportive supervisor
- Respect from other co-workers
- Orienting other staff to the peer specialist role
- Flexibility in defining role
- Support from other peer workers

Conversely, the following factors were identified as hindering the work of peer specialists:

- Lack of understanding of the peer role among peers, supervisors & colleagues
- Feeling in conflict with others on a treatment team
- Having job duties in misalignment with the ethics and values of the peer role
- Not being able to apply skills learned in CPS training
- Dealing with stigma
- Self-care/boundaries
- Working with people in crisis or in early stages of recovery
- System Issues: Peer specialists working in isolation, Paperwork language, Recovery model not embraced

The following are excerpts from the “*Evaluation of the Massachusetts Peer Specialist Training and Certification Program Final Report (Phase Two) – March 2011*” by the Center for Health Policy and Research at UMass Medical School.

### **I. Key Elements in the Successful Integration of Peer Specialists**

The following key elements were identified as important to the successful integration of peer specialists in the workforce.

#### A. Support from Higher Management:

Clear support for the peer specialist role from senior managers appeared to have a trickledown effect for the rest of the organization, according to many respondents. Peer specialists felt that their role and skills were valued throughout the entire agency when managers supported them. Examples of how leadership support was displayed included:

- Inviting peer specialists to be part of organization-wide committees and
- Hiring peer specialists into leadership roles where they provide supervision and support to peer specialist teams.

*I'm fortunate to have a regional director who is recovery-oriented. It's trickling down from my supervisor to others.*

*We have support from someone higher up in the organization who has lived experience.*

#### B. Supportive Supervisor:

Having a supervisor who they felt comfortable going to when issues arose helped many peer specialists feel supported in carrying out their role. The supervisor often insisted that others treat the peer specialist and his or her work with respect



*I feel much supported. I can do whatever I need to do. I can tell my supervisor I am having a hard time and I am supported.*

*I do feel respected by my boss. My two co-workers are not as familiar with the recovery movement. Sometimes I don't feel equal on the team. Sometimes I don't feel my role is valued and appreciated.*

#### C. Respect from Other Co-workers:

When working on multi-disciplinary teams, having the respect of co-workers made the peer specialist feel that their role on the team was valued. When this respect was clearly exhibited, peer specialists felt that they could do what they were trained to do. For example, one respondent was invited to train fellow co-workers on using person-centered language.

*With the traditional staff, I am treated with respect and dignity. I advocate for my clients to the staff and they respond to me with respect. I do feel like I am in a leadership role.*

#### D. Orienting Other Staff to the Peer Specialist Role:

A few respondents described the benefits of orienting all staff at the agency to the peer specialist role and where it fit into the organization prior to peer specialists working in the agency. They described instances where this orientation went well, and others where there was no orientation at all.

*I educated clinicians and staff at one location about peer specialists and their role before the peer specialists were working there. It was clear that it would be a challenge to have peer specialists there. The clinicians and staff wanted to talk about it. The ice was broken when the peer specialists started working there.*

#### E. Flexibility in Defining Role:

Because of the fact that the peer specialist role is still new to the traditional mental health setting, some respondents reported that they had the freedom to mold the role to best fit the situations where they were working. With this flexibility, peer specialists noted that they were free to use the knowledge and tools they gained in the training with their peers.

*There is a lot freedom to determine which way we want to go, especially being a non-profit. Plus, Peer Specialists jobs are so new, there is the freedom to do a lot.*

#### F. Support from Other Peer Workers:

For some respondents, it was important for peer specialists to have regular access to support from other peers working in the field. Many organizations that employ several peer specialists offered peer support meetings on a regular basis. Peers without this internal resource were sometimes able to access peer support through their Recovery Learning Communities (RLCs). Being the sole employee in a peer role within an organization leads to feelings of isolation. Many peer specialists said that hiring more than one peer worker was important to successful implementation.

## **II. Peer Specialists and supervisors of peer specialists identified barriers that peer specialists faced when working to apply their knowledge and skills training in their jobs**

### A. Lack of Understanding of the Peer Role among Peers, Supervisors and Colleagues:

In many settings, respondents described ambiguity surrounding the implementation of the peer specialist role. Many felt that having a better definition and description of the peer specialist's role and responsibilities would reduce this uncertainty. In many cases, clinicians and other staff reported not knowing what peer specialists are trained to do. As a result, it was not always clear to providers how to involve peer specialists in treatment- planning with program participants. This was particularly true for peer specialists working in Community-Based Flexible Supports (CBFS), where the requirement to provide peer support services was mandated by DMH with little guidance on how to implement it.

*People at the agency don't know what to do with the peer specialist role. They want to embrace the individual (the peer specialist) but don't know how to utilize what s/he has to offer. The clinician doesn't know when to ask the peer specialist to step in to help a client.*

Stemming from this ambiguity, some supervisors mentioned how difficult it was to provide supervision to peer specialists because they lacked (or a general lack of) an understanding about the role. In addition, supervisors found it hard to evaluate the performance of peer specialists without guidelines for what to expect. Both supervisors and peer specialists felt that more guidance from DMH would have made for a smoother implementation.

*I didn't get a 'how to' from CBFS and DMH. DMH doesn't have a standard definition of a certified peer specialist, that says 'here's what you need to do' and 'here's how it's measured' or a list of things a peer can do with a client and how to help them through the recovery process.*

### B. Feeling in Conflict with Others on a Treatment Team:

Peer specialists working on treatment teams sometimes had unique or differing viewpoints about the team's decisions and approaches to their working on behalf of a person using services. At times, the peer specialist was confident and shared his/her thoughts if they differed from those of the team. At other times, the peer specialist refrained from saying anything.

*Sometimes it is hard for a peer specialist to question the treatment recommendations made by their clinical counterpart.*

*When it comes to voicing their perspective, the power of the peer is very small... Sometimes they are the only voice on certain perspectives.*

C. Having Job Duties in Misalignment with the Ethics and Values of the Peer Role: Some of the job duties that peer specialists are asked to perform, such as serving as a Representative Payee or administering medication, were described as being in conflict with the ethics to which CPSs committed during their training. Peer specialists reported difficulty in reconciling their CPS ethics with their job duties.

*Also, being a Rep-Payee for persons served is challenging to do from a recovery orientation. We give them a check and they leave. How do we connect with people?*

*Someone I know who worked at another agency was having to do meds and be a Rep-Payee. There's no way to have mutuality doing those things because of the power differential.*

#### D. Not Being Able to Apply Skills Learned in CPS Training:

Some respondents indicated that some skills they learned as a CPS cannot be used in their jobs. Discussion revealed that this may be because the agency does not expect these skills in a CPS or the peer specialists felt these skills could not be used in their role. Advocacy on behalf of clients and dialogue about spirituality were two skills sets reported as being difficult to incorporate into a CPS's work with peers using services.

*The traditional system flies in the face of what you learned in the Peer Specialist training class.*

*Self-determination principles are hard to implement. Sometimes safety gets in the way. Our agency is in the process of changing so that clients are rewarded for behavior.*

*Some of the stuff we learned is hard to use with people who have been institutionalized for so long.*

#### E. Dealing with Stigma:

Stigmatizing beliefs and attitudes existed for many working in a peer specialist role, despite the best intentions of organizations and individuals. Co-workers sometimes viewed peer specialists first and foremost as "mental health consumers" and not as colleagues. Some peer specialists noted that sharing their recovery story with other staff can have a negative effect on their relationships with colleagues.

*What is unique to the peer specialist is that when something goes wrong for other people (who do not have a diagnosis), people say they are just stressed or burnt out, but when it is a peer, people say they're having a problem due to their mental illness.*

*If I share my story, it brings stigma out. Even people who want to be helpful have a stigma about the degree of mental illness a person has. People have said things to me, have asked me if I was sick like someone else.*

#### F. Self Care/Boundaries:

Several peer specialists reported that they often carried the difficulties of the people they serve home with them. It was challenging for many to leave people's problems at work. Some developed new skills and used additional support to manage their own recovery along with those they serve.

*I'm not sure what I'm doing emotionally with other people's experiences. How do I identify when I'm carrying too much from helping people?*

*I was not emotionally prepared for having to deal with my own recovery, other people's recovery and staff recovery all mixed in. The job is constantly edging into my own recovery. I needed to employ skills to maintain my own self-care.*

### G. Working with People in Crisis or in Early Stages of Recovery:

According to a few respondents, working with a peer specialist may not have helped someone new to their recovery. We heard from peers that it can be challenging to begin a relationship with someone who is in crisis or in an early stage of recovery.

*Sometimes, depending on where people are at, they see recovery as a big gap, something that's too big to attain. They look at me and say "Wow! Look at you. I can't get there." It's sometimes hard for them to relate to it.*

### H. System Issues

- Solitary Peer Specialist on Staff

Peer specialists noted that it is extremely challenging to fulfill multiple job responsibilities when there is only one peer specialist on a team. They expressed a strong desire for more peer workers in order to respond to the needs of the people they serve, and to educate fellow staff on the peer specialist role. Several peer specialists indicated that working as the only peer in an agency left them isolated and feeling alone.

- Paperwork Language

The paperwork requirements of many CPS jobs was time-consuming and took time away from peer support work. Having to document their work by using clinical "billable" language was also challenging. It is worth noting that each agency had different expectations about what CPSs should document and how it should be done.

*Another challenge is doing the paperwork, documenting the person so the person's idea and thoughts are expressed. But the paperwork is framed to get particular answers. It (paperwork and people's treatment records) should be an outlet for people to express themselves and be person-centered.*

- Recovery Model Not Embraced

Respondents noted that almost all clinicians have been trained in the medical model. The movement to more recovery-oriented services was experienced as a new way of doing things. Peer specialists said that this shift has been hard for many workers and has made the presence of a CPS, who embodies recovery, confusing and challenging for some staff.

At the agencies that have not fully embraced the recovery model, some peer specialists did not feel supported by management. Peer specialists suggested that some other staff, as well as policies, view the CPS role differently than CPSs were trained to do:

*Providers are not taking the course; they don't know what the CPSs are being trained to do. The non-peer traditional workers are not bad guys; they are not doing things wrong. This is just how they learned to work in the system.*

## 6.4 References

Davidson, L., O'Connell, M., Tondora, J., Stymon, T., and Kangas, K. (2006) *The Top Ten Concerns Encountered in Mental Health System Transformation*. *Psychiatric Services* 57(5):640.

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