2012 Update:
Status of the Developing Mental Health Peer Workforce in Massachusetts

Section 1: Introduction

Purpose: This paper reports on progress made and lessons learned since Transcom's[*] 2006 position paper, "Developing a Mental Health Peer Specialist Workforce in Massachusetts". The authors hope that people will be inspired and deepen their commitment to valuing and promoting the role of peer workers, who share their lived experience of mental health recovery throughout Massachusetts mental health services. This paper describes key opportunities and advocates for recovery-oriented change. It is intended to be used as a reference for people who make decisions about the strategies, policies, practices, and resources related to mental health recovery which support and guide communities across the state.

Massachusetts has taken bold and significant steps in recent years to transform its mental health services to promote recovery through policy and practice. This includes funding and other support for the emerging profession of Certified Peer Specialist (CPS). CPSs and other peer workers are widely employed in the state and perform many roles in diverse settings - as providers, administrators, policy makers, and more. At the national level, there is broad recognition that employing trained peer specialists throughout the workforce is a powerful means of infusing recovery principles into the day-to-day functioning of mental health services.

Certified peer specialists are people with "lived experience" of a psychiatric or co-occurring mental health-addictions diagnosis, mental health disability, extreme emotional states, or trauma who are trained and certified to use their lived experiences to help others drive their life and recovery in meaningful ways. CPSs, as well as other peer workers, serve as powerful role models and concrete examples that recovery is real for everyday people like those using public mental health services. Peer workers offer an authenticity and trustworthiness based on experiences that are directly relevant to the people they support. The skills and empathetic perspective of a peer worker inform and complement the work of other mental health professionals.

In 2004, Massachusetts received a "Real Choice System Change Mental Health Transformation Grant" from the Centers for Medicare and Medicaid Services (CMS). The aim of the grant was to promote recovery throughout the mental health service system with a particular focus on developing the role of Certified Peer Specialist and peer-operated services statewide. Authors of this paper, the Transformation Committee ("Transcom")*, initially came together as a steering

[*] Transcom is made up of individuals who represent peer-operated services (including The Transformation Center and six Recovery Learning Communities), service providers, state agencies and payers.

committee in support of the implementation of the grant. In addition to the 2006 peer specialist workforce paper and this 2012 update, Transcom has issued two other papers:

- ***Promoting a Culture of Respect:*** *Transcom's Position Statement on Employee Self-disclosure in Mental Health Workplaces* (Appendix A) and
- ***Peers as Valued Workers:*** *A Massachusetts Roadmap for Successfully Integrating Peer Specialists and Peer Support Workers into the Public Mental Health System* (Appendix B)

All three documents, along with other information about Transcom's work, can be found at: http://www.transformation-center.org/advocacy/policy/transcom/

Research demonstrates that the successful integration of certified peer specialists and other peer workers requires careful consideration, targeted policies, and concrete action. To gauge integration progress in Massachusetts, Transcom hosted several forums with informal advisory panels. These panels were organized to learn from four different stakeholder groups: peer specialists, "traditional" providers and administrators, Recovery Learning Communities (RLCs), and individuals using peer support. Through this inquiry, Transcom re-confirmed its goals:

- To expand, support and safeguard the emerging CPS role, integration of peer workers into the traditional workforce and peer-run community-based programs;
- To inform, educate and train on innovative recovery practices; and
- To advocate for funding for peer specialists and innovative recovery-oriented services.

Section II: Current Peer Support Activities in Massachusetts

A. Certified Peer Specialist Training

The Certified Peer Specialist (CPS) training was established in Massachusetts in 2006, through the joint efforts of The Transformation Center, Transcom and the Department of Mental Health (DMH). The CPS training prepares people for entry-level CPS positions. The CPS position itself, however, is not an entry-level position. People wishing to participate in the CPS training need to have a strong foundation in peer practice and recovery-oriented mental health services, and must be at a place in their personal recovery where they have the skills and supports to navigate a challenging work setting. There are also peer workers in the state, hired for their peer support skills and knowledge of recovery, who have not completed the CPS training and certification. Most current peer workers, however, were hired with the expectation of CPS certification within 6-12months. There have been few entry-level, part-time peer worker roles developed or funded under redesigned mental health services since 2006, when the efforts to establish CPS training, certification and roles began taking hold.

The goal of the Certified Peer Specialist Training Program is to establish a competent and high-quality workforce of CPSs employed throughout the state's public mental health services. To become a certified peer specialist in Massachusetts, individuals must complete the training program and pass an oral and written certification examination. This new workforce of CPSs is equipped to provide support, education, and advocacy in collaboration with people using services as well as those providing services. When the CPS role is understood and valued by agency leaders, CPSs are able to provide peer support and also function as change agents. CPSs who serve in the role of change agent are able to inspire a transformation in people's beliefs and practices toward recovery and assumptions about the people who are served by mental health services. To date, approximately 350 people have become CPSs in Massachusetts.

A team of CPSs facilitates the training and certification program at The Transformation Center, the statewide peer-operated training and technical assistance center in Massachusetts. The Transformation Center employs the training team, convenes the CPS Oversight Committee, and receives funding for the CPS program through a contract with DMH. No organization, however, has been authorized by the State Mental Health Authority to respond to the professional needs of the peer specialist workforce or to concerns raised about the ethical practices of CPSs.

The CPS curriculum's 34 training modules focus on building participants' skill competencies to work in peer specialist roles. Specifically, the training's objectives are to introduce to and develop in each trainee three high-level competency areas: providing peer support, acting as a change agent, and functioning as someone who is "in" but not "of" the system.

These competency elements consist of knowledge, skills, and attitudes in a variety of areas, including:

- How mutual peer support is used in the position of peer specialist
- How to share lived experience and tell recovery stories in an intentional, useful way
- How to inspire hope about the realities of recovery for people using services and people providing services
- How to be an effective change agent
- How to establish healing relationships with people using and providing services
- How to model and encourage the use of "self-help" strategies and tools that support and promote recovery

Once an individual successfully completes the training, passes the certification examination and commits to the CPS Code of Ethics (Appendix C), she or he becomes a CPS who has demonstrated the knowledge and skills to successfully fill peer specialist roles throughout the state's mental health system. Certification is not required for all peer worker jobs in the state, however, allowing for a workforce that encompasses a range of skill sets and experiences.

B. Use of Peer Workers in Provider Agency-Operated Programs

The peer workforce is expanding across the Massachusetts mental health services in a variety of provider agencies. The Department of Mental Health and the Massachusetts Behavior Health Partnership, with the support of MassHealth, were pioneers in contracting for peer specialists as part of treatment teams in Programs for Assertive Community Treatment (PACT) teams and Enhanced Day Treatment programs. Prior to that, peer-bridger programs at two Clubhouses and peer-debriefers at DMH state hospitals were early adopters of the "consumer-provider" role, an older model of employing people with lived experience in services. The current Certified Peer Specialist role, however, has clearly evolved in relation to these earlier positions.

Since 2006, people have been trained as CPSs in Massachusetts and in 2009, peer specialists were incorporated into redesigned Emergency Service Programs (ESP) and into DMH's Community Based Flexible Support (CBFS) services. CBFS programs make peer specialists available to service users in diverse ways, including hiring peer specialists as CBFS staff members and by sub-contracting to Recovery Learning Communities, who hire and/or supervise peer specialists. Peer specialists are also being employed in rapidly increasing numbers as "peer mentors" at DMH youth residential programs. It should be noted, however, that many individuals who are working as "peer mentors" have not participated in the CPS training.

Most of the current CPSs in the workforce are pioneers. They are working in uncharted waters within newly-established roles, in settings that have never incorporated staff with lived experience and/or in environments that do not support workers disclosing their lived experience. Often, the process of developing and integrating peer roles has occurred without adequate support, orientation and training for both peer and non-peer staff.

C. Use of Peer Workers in Peer-Operated Programs

Certified peer specialists, other peer workers, volunteers, and community-based resources are the backbone of peer-operated organizations. The infrastructure of the six DMH-funded Recovery Learning Communities (RLCs) provides a vast array of educational offerings and supports for people in recovery, including: skills training, leadership development, and opportunities for expanding networks and relationships at each individual's pace and level of commitment. RLCs also support CPSs and other peer workers who are employed in various settings in their regions.

D. Use of Peer Workers in State-Operated Programs

DMH created the Consumer Liaison Position more than 20 years ago. Since that time, DMH has incorporated people with lived experience in a variety of roles. Most recently, DMH established specific job titles and job descriptions for three levels of Peer Support Staff within state-operated services that achieved union approval. DMH also funds some of the provider-based programs employing peer workers, as described in section B, above.

Section III: Funding for Peer Specialists and Peer Workers

For over twelve years, fueled by decades of peer advocacy and supported by the combined efforts of Massachusetts Behavioral Health Partnership (MBHP) and DMH, peer workers and peer-operated programs have been funded in a variety of roles and initiatives aimed at developing peer support services across Massachusetts.

Although CPSs are already working in various DMH- and Medicaid-reimbursed programs, defining a CPS as a unique provider and/or service type would permit funding for peer support in clinical services. A letter was issued by the Center for Medicaid Services (CMS) to State Medicaid Directors in August of 2007 providing "guidance to states interested in peer support services under the Medicaid program." In February 2010, Transcom began to explore the possibility of obtaining Medicaid funding for CPSs. The National Association of State Mental Health Program Directors (NASMHPD) worked with Transcom to gather nation-wide data on Medicaid reimbursement for peer specialists. The results of the NASMHPD survey are available online at http://www.nasmhpd.org/PeerSupportServicesSurvey.cfm

Transcom has gathered the information needed to complete the CMS application, which is required for establishing CPS as a unique and reimbursable provider type. The proposal was presented to MassHealth for input. In order to pursue Medicaid financing for peer specialists as a unique provider type, however, it is necessary for the State Mental Health Authority to authorize a certifying agency for CPSs in Massachusetts.

It is likely that the expansion of the peer specialist role and workforce will also continue from several new opportunities under development as Medicaid demonstration projects, including "Money Follows the Person Demonstration" and "Demonstration to Integrate Care for Dual Eligible Individuals." These projects will authorize payment for a designated number of peer roles within specific MassHealth waiver programs, but do not make the role of CPS universally reimbursable under MassHealth.

Ultimately, MassHealth will select the funding authority/ies through which certified peer specialists may deliver services in Massachusetts and will identify the Commonwealth's next steps toward securing additional funding.

Section IV: Evidence Base for Peer Support

A significant amount of published literature on how peer specialists have been integrated into mental health services and the value of receiving support from peer specialists. Additional evaluations of peer specialist services have been conducted specifically in Massachusetts. A brief overview of this literature can be found in Appendix D.

Many themes found in the Massachusetts studies are consistent with research findings from other locations. The following three themes are particularly relevant:
(1) a poor understanding of the value and intent of the peer specialist role hinders the integration of peer specialists, (2) hiring practices and staffing patterns that prevent peer specialists from working in isolation from each other are essential and needed to foster flexibility and collaboration in implementing the role, and (3) proactive leadership, staff orientation, and training in advance of the new peer workforce help non-peer staff and others in the organization prepare for change.

Section V: Recommendations and Lessons Learned for the Successful Integration of the Mental Health Peer Workforce in Massachusetts

In this section, we offer six time-sensitive, actionable recommendations to address systemic challenges that interfere with the successful integration of peer workers. These recommendations are informed by Transcom members' shared expertise and arise from a review of information obtained from three sources: (1) a series of four forums hosted by Transcom which gathered feedback from peer specialists, non-peer providers and administrators, Recovery Learning Community leaders, and persons using peer support services, (2) survey data from DMH, and (3) evaluation studies conducted by the Center for Health Policy and Research at UMass Medical School (Appendix E).

Given that the wellbeing of community members and the existence of effective health services are desired outcomes, it is urgent that leaders take even small steps and make concrete commitments toward every one of these recommendations. Since each is substantial and may require years to fully implement, immediate and creative action is all the more necessary in order to further develop the peer workforce during this era of change and instability.

Recommendation 1:
Clarify and promote fidelity to Certified Peer Specialist standards and best practices through a web-based portal.

Lessons Learned

There remains widespread confusion regarding the CPS and peer worker roles and the core competencies of peer specialist practitioners. This is seen in hiring practices that focus solely on "lived experience" and fail to address skills necessary to performing the job. Many peer workers have been hired into positions with vague job descriptions and are supervised by individuals unfamiliar with the supervision needs of a CPS or with peer support practices and peer specialist competencies. As a result, CPSs have been asked to perform tasks that are inconsistent with their professional training and incompatible with the CPS Code of Ethics. There is no authorized authority to guide and ensure effective and ethical practice. In addition,

some employers fail to distinguish between CPS certification course attendance and attaining certification, thereby compromising the quality of the peer workforce and perpetuating misconceptions about the value of the role. Often, if a student in the CPS training does not pass the certification exam or decides not to take it, there are no consequences within his/her work setting or plans for how to support person to continue pursuing certification.

Discrimination and stigma underlie some of the environments in which CPSs work, which devalues CPS experience, skill and practice. A setting in which non-peer professionals with their own lived experiences are not valued and supported in disclosing those experiences can send the message to peer colleagues that there is shame in having a history of a mental health diagnosis. Some peer workers report that they are hired and treated as "clients" and that other workers or supervisors see the peer specialist job as part of their ongoing treatment and rehabilitation.

Action Steps

- **Develop a web-based portal for CPS standards and best practices in all peer support roles** – A CPS portal should be created in consultation with a state-authorized CPS authority to ensure alignment with CPS Certification. Training materials should be provided in a variety of media, including written, video, PowerPoint, and interactive formats. The CPS portal needs to feature key materials, including the CPS Code of Ethics, the basics and best practices of peer support, guidance for Human Resources Departments and sample job descriptions. "Readiness guidelines" and self-assessment tools should be available for organizations that plan to integrate the CPS role into new or existing services.
- **Define and clarify CPS competencies consistently throughout the state** – Describe essential CPS competencies and recommend their use as cornerstones for developing job descriptions and training.
- **Align CPS job descriptions with CPS competencies and the CPS Code of Ethics** – Establish systems for supporting the integrity of peer support and hold funders, providers, and community members accountable for the day-to-day work of culture change.
- **Expand learning opportunities to agencies, communities, and groups that share an interest in peer support and recovery** – Establish a peer-based, state-wide coalition of trainers to provide training and orientation to the CPS portal and recovery supports.
- **Uphold CPS certification standards** – Expect employers to maintain professional standards for the emerging field by requiring certification of "peer specialists," as opposed to peer workers or other peer roles, within a specified period of time.
- **Support familiarity with Transcom's *Promoting a Culture of Respect* statement** (Appendix A) – Encourage providers and community members to review this brief document about disclosure and use it to facilitate discussions within the agency.

Recommendation 2:
Ensure that every peer specialist interacts regularly with a CPS supervisor and peer colleagues.

Lessons Learned

As with all professionals starting work in their fields, an entry-level peer specialist grows when he or she is supervised by someone with more experience in peer support and recovery education. While others within an organization can provide useful administrative supervision, in order to receive supervision specific to the role and to strengthen a shared sense of professional purpose, it is vital for CPSs to work with each other and have access to supervision with other qualified peer specialists.

Action Steps

- **Fund and establish senior CPS supervisory positions** that have the authority and time to work with every peer employee.
- **Consider subcontracts with Recovery Learning Communities to provide CPS supervision** from the perspective of a community base and beyond the agency.
- **Train administrative non-peer supervisors** to respect the skill set, expertise, and experience of the peer workers they support.
- **Encourage training of all supervisors** to distinguish the role of professional supervisor from that of therapeutic supporter.
- **Ensure access to professional development** for peer workers within the organization, consistent with access other professionals have to opportunities for growth.
- **Create an infrastructure for peer workers in similar roles** across agencies to collaborate. The PACT Peer Recovery Specialist model of peer-to-peer professional development is a Massachusetts-based example of success.

These strategies will help to:

- ✶ Ensure the effectiveness and desired outcomes of peer practitioners in health services.
- ✶ Expand and diversify the peer workforce, including specializations relevant to shifting service models.
- ✶ Increase the belief in and commitment to a recovery vision due to greater exposure of service users and providers to successful peer workers.
- ✶ Facilitate collegial support among peer workers, thus reducing isolation and increasing unity and a sense of professional identity and
- ✶ Foster leadership and professional integrity among peer workers.

Recommendation 3:
Build a broader continuum of peer specialist roles by establishing more entry-level peer worker positions and a CPS Continuing Education (CE) infrastructure.

Lessons Learned

There is a gap in services that can be filled by increasing the number of part-time, entry-level peer worker positions that are supervised by CPSs with more experience and training. A larger number of people will benefit from peer support if such part-time roles are fully supported with supervision by a CPS and a curriculum to guide experiential learning in a variety of settings. Without a CE structure, Medicaid funding for CPSs as a unique provider type will not be approved.

Action Steps

- **Develop a pre-certification, work-based training, and entry-level peer worker position** to help individuals gain skills practice, supervision, and employment experience. This will better prepare people for the next step in their career path, whether it is applying for the CPS training program or choosing another vocation.
- **Develop a database** of active CPSs in Massachusetts that can be accessed by the public, consistent with other professional certifications.
- **Develop a CE infrastructure** facilitated by the organization authorized to certify CPSs and in collaboration with Recovery Learning Communities. Like other professional training programs, the CPS program is meant to be an entry-level training accompanied by annual continuing education requirements to maintain certification and develop expertise in specific areas or roles. To accomplish this goal, the certifying agency should be contracted to create a continuing education component consistent with other professional certification programs.
- **Approve CE requirements** for all CPSs and track each CPS's successful completion of those requirements to ensure ongoing professional development, consistent with other professional certifications.

Recommendation 4:
Allow for flexibility in the CPS training model while maintaining consistent standards for certification.

Lessons Learned

In order to increase the number of individuals fully employed and providing the benefits of a trained CPS, more people need to successfully prepare for the training, complete the certification process, find satisfying and sustainable employment, and continue professional development once working in their field. These aims can be met by making the CPS training more flexible and responsive to diverse communities and learning styles.

Action Steps

- **Continue modifications to the CPS training curricula and exam for greater accessibility.** Build modules based on CPS concepts and competencies and incorporate every-day language, visual cues, stories, experiential learning, and skills-based examination. This will increase access while maintaining a single, consistent certification standard that indicates a uniform set of CPS skills.
- **Modify the CPS Examination to be as close to culture-neutral as possible.** Align testing so that people of many cultures and languages can answer questions within their own cultural frameworks, while also being able to demonstrate competencies and, therefore, meet standards for passing the exam.
- **Extend relationships with peers in culturally diverse** and/or non-English speaking communities to ensure that training curricula takes into account how various cultures view aspects of the CPS role, including: peer support, mental health diagnosis, and how "help" is defined.
- **Make structural changes to the training day** to accommodate the learning styles of young adults. Make language changes that reflect young adult experiences and services, including more information about "resiliency" in the curriculum.

Recommendation 5:
Promote "Universal Human Resource Design" with robust policies that maximize employment conditions for all employees.

Lessons Learned

Human resources policies that maximize opportunities for all workers, peer and non-peer, have been identified and can replace policies that are rigid or have become ineffective for everyone - those who enforce them and workers who are impacted by them. CPSs are the first to reject HR practices that offer flexibility solely for peer workers, which creates resentment and furthers stigmatization in the workplace.

Action Steps

Universal HR Design can be achieved by taking these steps:

- **All positions, including peer specialist positions, should require relevant training and preparation.** Human resource policies should recognize and value the knowledge and skills gained from "lived experience" and not inflate the significance of academic credentials that are not indicators of competence in peer support skills.
- **Human resource staff should be skilled in creative and adaptive staffing, including use of Americans with Disabilities Act (ADA) accommodations for all personnel.** Many workers, including peer workers, benefit from creative staffing adapted to the

needs of workers and agencies. Knowledge of ADA accommodations, flex-time, shared positions, etc., improves the work environment for many employees, including people with lived experience, parents, and people with physical disabilities.

- **Maximize insurance benefits** that contribute to the security, wellness, and productivity of all employees. Improve the health of all workers and the organization by training HR staff to support employees in accessing a wider variety of resources, including Medicare, Medicaid, SSI, SSDI, Social Security Work Incentives, FMLA, and Veteran's benefits.

Recommendation 6:
Provide new financial resources to support the peer workforce.

Lessons Learned

The CPS Financing subcommittee of Transcom has explored a range of funding options used by other states to support services delivered by peer staff. The group focused primarily on various Medicaid funding authorities (e.g., State Plan and waivers) used by those states. Transcom concluded that, in light of a number of current competing initiatives and funding priorities in Massachusetts, the Commonwealth is not prepared at the present time to pursue expansion of certified peer specialist or peer support services through these Medicaid authorities.

For its own inpatient and community-based services, the Department of Mental Health has recently hired a number of peer specialists and intends to hire additional staff. The hiring of these staff follows a lengthy process by DMH to develop job descriptions and salary ranges for three levels of Peer Support staff, which have been designed to not only expand the numbers of peer staff but encourage their career growth within DMH services.

*In addition, several important statewide Medicaid initiatives are under development that will incorporate peer support as a key element. In response to federal initiatives contained within the federal Affordable Care Act, Massachusetts is developing separate demonstration proposals to: (1) integrate care for individuals who are both Medicare and Medicaid-eligible (**Integrated Care for Individuals with Dual Eligibility**), and (2) to move individuals residing in certain institutions back to the community with wraparound services (**Money Follows the Person**). Both of these initiatives will incorporate peer specialist services. The larger and faster-track Dual Eligible Demonstration will support the employment of peer workers to promote recovery and help access and integrate care for individuals with mental illness, addictions, and physical health conditions. Transcom members are supporting these important efforts, which are already underway and will potentially expand the roles and numbers of peer specialists in the state.*

Many of the advances in services delivered by peer specialists and/or peer support workers have been initiated and supported by MassHealth's behavioral health contractor for its Primary Care Clinician Plan, Massachusetts Behavioral Health Partnership, through both its Medical

Services budget and Administrative budget. It is hoped and anticipated that MassHealth will continue and/or further develop many of these initiatives in its upcoming PCC Plan contract effective FY2013.

Transcom will continue to watch for opportunities to pursue additional funding for peer specialists as a unique provider type and/or covered service in the future.

Action Steps

- **Continue to expand CPS services that are embedded in other covered service programs** in order to increase the number and range of work environments for CPSs in Massachusetts. This should include a mechanism for ensuring that positions titled "Certified Peer Specialist" function as a peer specialist and not as a generalist, clinician or other type of worker.
- **Expand the use of CPS and peer worker services** in new Medicaid statewide initiatives being developed by the state in conjunction with the federal Affordable Care Act. The expansion of service types under Medicaid Demonstration programs provides the ideal opportunity to develop a career ladder and diversification of peer roles, including: entry-level and part-time peer workers, peer bridgers, wellness coaches, vocational peer staff, emergency services peer support, peer trainers, CPSs, and CPS supervisory and administrative roles.
- **Promote opportunities for Medicaid reimbursement** for certified peer specialists as 22 other states have done. Advocate for CPS services to be billable as a unique provider type and as a covered service, including a State Plan Amendment articulating standards for peer specialist providers. Opportunities are passing the state by as the Affordable Care Act engages medical settings in increasing integration of health and behavioral health care. A barrier to innovation exists as a result of lack of such a State Plan Amendment. Successful completion of this would open the door for peer work in clinic and elder services, young adult services under the Children's Behavioral Health Initiative, certain medical home initiatives and more.
- **Continue to seek other creative funding opportunities for peer support services.**

APPENDICES

A. "*Promoting a Culture of Respect: Transcom's Position Statement on Employee Self-disclosure in Mental Health Workplaces"*

B. Letter to Commissioner Leadholm
"Peers as Valued Workers: A Massachusetts Roadmap for Successfully Integrating Peer Specialists and Peer Support Workers into the Public Mental Health System"

C. Certified Peer Specialist (CPS) Code of Ethics

D. Brief Literature Review

E. Massachusetts-Based Studies of Peer Specialists

F. References

G. History of Funding in Massachusetts

PROMOTING A CULTURE OF RESPECT

Transcom's Position Statement on Employee Self-Disclosure in Mental Health Service Workplaces

As members of the Massachusetts Transformation Committee (Transcom), we support the vision of a state-wide network of activities and services driven by the wisdom and needs of people in recovery from mental health conditions. We believe in the value, utility and inspiration that comes from hearing another human being share his or her personal story. As research and experience supports, people are more inclined to build and sustain their efforts at recovery and rehabilitation when they are encouraged by those who have been challenged by similar circumstances.

We are committed to the ongoing development of respectful interactions within our own environment, the mental health service system. We look forward to a time when the disclosure of a mental health or substance abuse condition within the workforce is not associated with shame or bias.

OUR PURPOSE

This statement is intended to encourage organizations to fully support and value all staff who wish to share their own triumphs and challenges from a variety of realms. An open environment where diverse life experiences are shared is necessary to the success of staff who disclose that they live meaningful lives with mental health difficulties.

By encouraging responsible and open exchange, we hope to inspire inclusion and a culture of respect for people with mental health conditions, not only within the mental health workforce, but within society as a whole.

A number of organizations have thought about these issues and support and recruit employees who disclose their mental health conditions. We are encouraged by their leadership. We hope that this statement stimulates energetic dialogue about policies and practices related to personal disclosure in every workplace.

THE WORKFORCE OF PEOPLE IN RECOVERY

Many individuals in the workforce have mental health conditions and many do not always feel comfortable or welcome to share their expertise. We recognize that agencies and employees are at various stages of awareness about the benefits and responsibilities of a work culture that values the experience of people in recovery from mental health conditions. Advocating for the support

of personal disclosure means confronting long-standing principles that advise against personal sharing which are still practiced by many organizations and professional schools. While recognizing that this perspective might be new for many, we endorse a system that views voluntary, personal disclosure within the context of helping relationships in a positive light.

Disclosure of a mental health condition by employees 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. It is a worthwhile effort! The sharing of human difficulties and limitations by staff helps to create a system where these experiences are not seen as the monopoly of clients. As with any communication in the workplace, we expect that decisions about disclosure to clients 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, which is personal and voluntary.

In addition to workers in a variety of positions in the field who use self- disclosure to assist others, the system now includes staff who are expected to disclose and have clearly identified "peer" responsibilities. In Massachusetts, efforts are underway to recruit, train and develop a statewide workforce of Peer Specialists, people with mental health conditions who are hired to draw on their personal experiences to promote recovery.

APPRECIATION FOR PIONEERS

People who have chosen to self-disclose with care and consideration at their jobs and those entering the workforce as Peer Specialist are true pioneers. Such employees are actively participating in creating a more inclusive, open, and empowering work environment. Peer Specialists, in particular, experience the joy of helping others while facing the tremendous pressure of breaking new ground in an extremely demanding field.

Transcom appreciates the strength and resilience of both Peer Specialists who are "the first" to work in the system and other workers who are "the first" to disclose in their organizations. It will be critical that organizations develop and share innovative training, supervision and other practices to meet the employment needs of Peer Specialists. We recognize that employers will need to be creative as they nurture and support all workers who encounter the inevitable challenges that come from being in the forefront of change.

Endorsed unanimously by members of Transcom February 23, 2007

Transcom Membership ~ 2-23-2007

Name	**Organization**
Karl Ackerman	Transformation Center Board Member, MDDA-Boston
Moe Armstrong	Peer Educators Project
Chris Busby	Consumer Quality Initiatives (CQI)
Linda Cabral	Center for Health Policy and Research (CHPR)
Clara Carr	Massachusetts Behavioral Health Partnership (MBHP)
Deborah Delman	M-POWER / Acting Director, The Transformation Center
Jon Delman	CQI
John Deluca	MassHealth Behavioral Health Programs
John Frazier	Massachusetts Organization for Addiction Recovery (MOAR) and CQI
June Gross	MBHP
Steve Hahn	Mental Health/Substance Abuse Corporations of MA (MHSACM)*****
Sara Hartman	MHSACM*****
James Hiatt	Bureau of Substance Abuse Services (BSAS)
James E. Henry	Transformation Center Board Member
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Debra Hurwitz	CHPR
Jill Lack	Neighborhood Health Plan
Betty Maher	Mass Rehab Commission (MRC)
Eric Masters	CHPR
Dana Moulton	MOAR, Transformation Center Board Member
Michael O'Neill	DMH
Anne Pelletier-Parker	MBHP
Linda Rost	AdLib, Inc.
Bob Schueler	Mass Psychiatric Rehabilitation Association
Heather Strother	CHPR
Howard Trachtman	Boston Resource Center
Marcia Webster	CQI

****** In 2009 MHSACM became the Association for Behavioral Health (ABH)***

March 31, 2008

Commissioner Barbara Leadholm
Department of Mental Health
25 Staniford Street
Boston, MA 02114

Dear Commissioner Leadholm:

The Massachusetts Transformation Committee (Transcom) and its "Integrating Peer Workers into the Workforce" subcommittee are pleased to submit the following policy recommendations and executive summary for your consideration, *Peers as Valued Workers: A Massachusetts Roadmap for Successfully Integrating Peer Specialists and Peer Support Workers into the Public Mental Health System.*

As you know, Transcom is a broad-based coalition committed to building consensus and to strengthening mental health supports that are person-driven and sustainable throughout the Commonwealth. The following comments from six people at Baycove Human Services remind us of what is at stake and about what is possible when peers are integrated into the provider workforce:

> *How can you build a beautiful stone wall without experienced masons? Non-peer staff can provide the mortar, tools and stones. But you need a master to teach an apprentice.*
>
> *Through interactions with staff peers and the CPS, you experience the good feeling in your heart and brain when it dawns on you that they understand your struggles…An integrated staff is a creative and efficient collaboration. It demonstrates that Recovery/Procovery is not just a current catch phrase.*
>
> Carolina Mucci, Rehab Center Member
>
> *Peer workers have an extra point of view as a "peer" that is an invaluable resource for reality testing ideas and checking regressive thinking.* Vocational Rehab Provider
>
> *Therapeutic boundaries which were so emphasized in my training are effectively renegotiated day to day. New and more flexible boundaries had to be identified and power the recovery process.*
>
> Denise Clarke, Certified Peer Specialist
>
> *I have had my own psychiatric experience…I never shared this with a co-worker until I began working with our Peer Specialist.*
>
> Vocational Rehab Provider

The consumer staff has an opportunity to be "out" about their illness, while the non-consumer staff benefit from the consumer staff's insight and experience… Having a consumer-staff gives us a great opportunity to reduce stigma.

David Selkovits, Certified Peer Specialist

Every day, I have clear examples of people in recovery…To keep peer workers out of your agency's workforce is to deprive both your staff and your members of the most concrete experience of hope.

Working as a member of an integrated service team…is liberating. Together, we demonstrate to our clients – and even our society- what is possible.

Brad Day, Assistant Program Director

We are confident that following this "roadmap" will help us generate many more experiences like these! Please be assured that Transcom is available to respond to your questions and ideas about the proposed roadmap and related projects.

Sincerely,

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Peers as Valued Workers: A Massachusetts Roadmap for Successfully Integrating Peer Specialists and Peer Support Workers into the Public Mental Health System

Executive Summary

"The hope and the opportunity to regain control of their lives- often vital to recovery- will become real for consumers and families. Consumers will play a significant role in shifting the current system to a recovery-oriented one by participating in planning, evaluation, research, training, and service delivery."
Achieving the Promise: Transforming Mental Health Care in America

Transcom's Vision for Successful Integration of Peer Workers[1]:

We envision a system where people in recovery have guaranteed access to certified peer specialists and peer support workers throughout Massachusetts, whether through an agency where they receive services, from a Recovery Learning Community or from another peer operated program. Peer Specialists and Peer Support Workers will serve as critical role models for their peers and colleagues that recovery is possible and achievable. Their unique roles and job functions will be understood and valued by their peers, their colleagues and supervisors. They will be equitably reimbursed and supported in their primary focus of advocating for the consumers they work with.

Inspired by the vision and recommendations of the President's New Freedom Commission on Mental Health, people in recovery are taking an active role in Massachusetts to transform its public mental health system. One critical element in this transformative work is people in recovery working as peer specialists and peer support workers in traditional provider agencies and consumer operated organizations.

As traditional mental health providers begin to see the value and importance of these roles in their own programs, the demand is increasing for certified peer specialists and peer support workers. With this increasing demand comes the need to develop infrastructure and supports that will ensure the success and sustainability of these roles over time.

Responding to this need, the Transformation Committee (Transcom), a state level partnership of people in recovery, provider agencies, stage agencies, and other advocates, is committed to achieving the successful integration of peer specialists and peer support workers throughout the public mental health system. Transcom charged a subcommittee to develop a roadmap for achieving successful integration of peer specialists and peer support workers throughout the state's public mental health system.

The purpose of this roadmap is to offer policy recommendations to the Department of Mental Health on how to successfully integrate peer specialist and peer support services throughout state's public mental health system.

[1] The term peer workers refers to both certified peer specialists and peer support workers when recommendations apply to both of these types of individuals.

Transcom members are excited to provide this roadmap to the leaders of the Department of Mental Health, and look forward to collaborating on achieving its vision.
The roadmap begins with defining a vision for the successful integration of peer workers. It then sets out short and long-term objectives in eight domains that are critical for achieving the vision. Each domain section also includes a brief description of its purpose or why addressing the domain is crucial for success.

Domain 1: Define Roles and Functions of Certified Peer Specialists and Peer Support Workers

The roles and functions of certified peer specialists and peer support workers are seen as valuable and essential to the work of the state's public mental health system.

Short Term Objectives:
1. Standard definitions of PSW and CPS are in effect across the public mental health system and other state health and human service agencies.
2. DMH encourages providers to incorporate these roles into their organizations.
3. DMH increases their own employment of peer workers throughout their programs.

Long Term Objectives:
1. DMH requires providers to incorporate these services into their organizations.
2. CPS and PSW are adequately funded and available in all service types.

Domain 2: Articulate the Value of Certification for Peer Specialists

A specialized workforce of Certified Peer Specialists exists to offer education, advocacy and support to their peers.

Short Term Objectives:
1. DMH continues to fund peer specialist trainings.
2. The peer specialist training and certification program is evaluated for continuous improvement opportunities.
3. Certified peer specialists are reimbursed at a level equal to other similarly qualified professionals in their organizations.

Long Term Objectives:
1. Other sources of funding are secured to support additional peer specialist trainings (e.g. providers and other state agencies fund slots for their clients).
2. Community colleges recognize the value of peer specialist training and certification and offer credit towards a degree for those who successfully complete the training and certification program.
3. Additional tracks for specialized training (e.g. documentation and paperwork, employment, benefits, housing, trauma-informed care, etc.) and advanced certification are developed.

Domain 3: Provide Training and Continuing Education for Peer Workers

Peer Specialists and Peer Support Workers are able to continuously develop new skills and expertise that have a foundation in their lived experience of recovery.

Short Term Objectives:
1. Opportunities for peer specialist and peer support worker continuing education are funded by DMH and providers.

2. The Transformation Center articulates and monitors continuing education requirements for certified peer specialists.

Long Term Objective:

1. Specialized training and continuing education in areas such as housing, benefits, employment, and trauma-informed care are available to further develop the skills of peer specialists and peer support workers.

Domain 4: Fund Peer Specialists and Peer Support Workers Appropriately

Peer services are so integral to the system's success that every funding stream includes dedicated dollars for peer services.

Short Term Objectives:

1. Working with Medicaid and other state agencies, DMH investigates all avenues for additional funding of peer services.
2. Demonstration projects integrating peers are established and evaluated for their effectiveness.

Long Term Objectives:

1. Lessons learned from demonstration projects are shared with the provider community to assist them with integrating peer workers.
2. The increased integration of peer workers is reflected in program and budget restructuring.
3. Medicaid financing is implemented for funding peer specialist services.

Domain 5: Train and Educate the Provider Community on Integrating Peer Roles

DMH leads sustained educational & training opportunities for the mental health workforce to assure that peer workers are treated as and considered colleagues of value.

Short Term Objectives:

1. DMH articulates a vision for how recovery oriented principles and peer specialists/peer support workers are to be integrated in provider settings.
2. A statewide committee of diverse membership convenes to develop a curriculum for providers on integrating peer workers into their agencies.
3. Knowledge of people in recovery informs the content and structure of training and education opportunities.

Long Term Objective:

1. The Transformation Center, in collaboration with Recovery Learning Communities, are funded to coordinate and provide training and education to the provider community and DMH on how to best integrate peer workers.

Domain 6: Offer Technical Assistance to Providers on Workplace Issues

Mental Health provider agencies are exemplary employers of people with lived experience.

Short Term Objectives:

1. Mental health providers develop networks to share best practices and lessons learned in successfully employing peer workers.
2. Transformation Center develops and disseminates practical resources to providers to assist them with personnel issues.

Long Term Objective:

1. The satisfaction, success, and well-being of people employed as peer specialists and peer support workers significantly increases.

Domain 7: Promote and Facilitate Organizational and Cultural Changes Across Mental Health System

Policies and procedures support and enhance strengths-based services by peer and non-peer professionals in a culture where all are respected for their unique role in the partnership. All people's lived experience is sought and valued in a safe and supportive environment.

Short Term Objectives:

1. Agencies are familiar with Transcom's statement "Promoting a Culture of Respect" and adopt its vision by strengthening practices that support dialogue and self-evaluation.
2. DMH creates a task force to review policies and regulations to ensure that they are in alignment with recovery oriented practices

Long Term Objective:

1. DMH makes every effort to change policies and regulations that pose barriers to recovery-oriented practices and successful peer integration.

Domain 8: Conduct Research and Evaluation to Maximize Success

Maximize the effectiveness of peer workers through research and evaluation initiatives conducted by a partnership of consumer researchers, academic institutions, and the Department of Mental Health.

Short Term Objectives:

1. Conduct pre/post evaluations of trainings related to integrating peer specialists or peer support workers into the workforce (e.g., peer specialist trainings, provider trainings, etc) with follow-up assessment to determine whether gains are sustained over the long term
2. Conduct additional qualitative work on how certain mental health programs have achieved successful integration of peer specialists and/or peer support workers
3. Build the capacity of consumer run organizations to evaluate their own services and activities.

Long Term Objective:

1. Conduct a major implementation study exploring the process and outcomes of how peer workers are integrated throughout Massachusetts using a longitudinal design.

Next Steps

The responsibility of successfully integrating peer workers into the public mental health belongs to all individuals and organizations that are committed to promoting recovery. Transcom is eager to partner with DMH to explore the operationalization of this roadmap. The vision and objectives set forth in this road map are part of a greater vision for mental health services that is in alignment with DMH's strategic plan.

Some next steps may include:

- Convene diverse stakeholder groups to discuss how to implement roadmap objectives
- Develop subcommittee(s) to begin implementing roadmap objectives
- Consider how to use the upcoming DMH reprocurement to achieve short term objectives
- Collaborate with MassHealth on exploring financing mechanisms for Peer Specialist services

Massachusetts Certified Peer Specialists
Code of Ethics

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. Further revisions completed in the summer of 2008.

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

1. The primary responsibility of Certified Peer Specialists is to help individuals 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 from mental illness and will likewise be able to identify and describe the supports that promote their recovery.

4. Certified Peer Specialists will, at all time, respect the rights and dignity of the people with whom they work.[1]

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, sex, 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.

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[1] *CPSs interact with many people in their professional life, including service users, peer and non-peer colleagues, and people from a wide range of professions and positions. CPSs must remain true to the Code of Ethics in all of these professional dealings to maintain integrity for themselves, the people they serve, and the new profession.*

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 individuals 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 5 years.

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, nor accept gifts of significant value from those they support.

14. Certified Peer Specialists will not provide services 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
(Print your name)

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: _____

D: Brief Literature Review

A growing body of research reveals many benefits of employing peer specialists in mental health settings. Several studies indicate that peer-provided services are as effective as non-peer provided services or in some cases more effective. Examples of beneficial outcomes based on peer specialist services include: reductions in hospitalization, improved social functioning, and reduced substance abuse (Davidson 2006; Solomon 2004; Chinman 2006; Mowbray 2006). In another study, Felton and colleagues (1995) compared outcomes of people assigned to three different case management models, one of which included a peer specialist team member. Individuals served by a team that included a peer specialist experienced gains in some aspects of quality of life, fewer significant life problems, and improved self-esteem and social support.

Other studies, however, have not shown differences in outcomes when using a peer specialist. In a study by Solomon & Draine (1995), clients randomly assigned to a case management team comprised of either all peers or non-peers found no differences on a variety of standardized measures of function and symptoms. Similarly, in a study by Rivera (2007), people were randomly assigned to either peer-assisted case management, non-peer assisted case management, or to standard clinic-based care. Over time, all three programs yielded the same general pattern of improvement in symptoms, health care satisfaction and quality of life.

While the literature notes mixed responses to the inclusion of peers as service providers, many investigators note that peer specialists bring unique qualities to the mental health workforce. Based on their lived experiences of mental health diagnoses and recovery, peer specialists have a deeper understanding of the challenges which someone using mental health services is facing when compared to professionals who offer other types of expertise. CPSs are trained to listen, understand and respond from the perspective of sharing a human experience that is usually stigmatizing. Therefore, peers using services and peer specialists employed to support them often share a bond. This helps in building trust even when connections and understandings with providers and the system are not established or have broken down. Peer specialists serve as positive role models for coworkers and for people working on their own recovery. This new workforce inspires hope for recovery in every support service. The peer specialist also shares his or her first-hand knowledge of human service and benefit programs and how to negotiate them, with peers using services and with co-workers.

Peer specialists play a vital role in bridging the gap between “clients” and “professionals”, helping them to better understand each other’s needs, and educating their coworkers from the point of view of someone who uses services. Exposure to people who are in recovery and fulfilling valued roles as trainers and colleagues has been found to reduce stigma and discrimination (Solomon 2004, Mowbray 2006; Dixon 1994; Dixon 1997; Grant 2010; Chinman 2006. Paulson 1999).

<u>Factors that Impact the Integration of Peer Specialists into the Mental Health System</u>
Several studies have identified factors that <u>facilitate</u> the successful integration of peer specialists into mental health agencies. They include:

- Taking steps to help peer specialists feel included within the team,
- Support for integration from the mental health agency or program,
- Making ongoing coaching and mentoring available,

- Establishing opportunities for training, education and advancement, and
- Being regarded as an equal and a colleague by co-workers

(Mowbray 1996; Grant 2010; Gates 2007)

Studies also show that peer integration is more successful when leaders facilitate an understanding among all staff of the importance of the peer role in the agency's mission. One factor that Chinman (2006) describes as helpful is for agencies to hire more than one peer provider. Having just one person with lived experience on a staff team places considerable pressure on the individual to represent all people in recovery and can make it more challenging to integrate peer specialists fully into the workforce. When building a culture supportive to integrating peer specialists within the agency, sufficient structure is necessary. This includes examining Human Resources policies, making statements on boundaries and ethics, and using increasingly respectful language, documentation and service planning (Gates 2007; Chinman 2006; Mowbray 1996). Paulson (1999) suggests adjusting staffing patterns to allow any worker who needs it the option of flexing their schedules in order to maintain their well-being and capacity to work.

Several studies underscore the importance of clearly defining peer roles in order for successful integration to occur. As with any worker, consistent supervision that focuses on job performance and feedback and career development, as opposed to personal issues, is essential to the success of this emerging profession. Many of the factors described above can also become barriers if agencies do not address them adequately.

Several studies identify additional factors that hinder the integration of peer specialists, including:

- poorly defining the role of a peer specialist which leads to role conflict and confusion,
- lack of policies and practices around confidentiality,
- stigma towards the peer provider,
- difficulty shifting the culture and practices from a clinical model to a recovery model,
- lack of information for the peer specialist to do his or her job, and
- the need for more training and guidance.

Hiring peer specialists also raises questions about "boundaries", or how to negotiate multiple roles and multiple points of contact. Established professionals are often concerned that the people they serve will not respond well or be treated properly by a staff who discloses that s/he is in recovery. Peer specialists may feel torn about responding to a peer using services as a friend and/or a service provider. Role confusion and guidelines for engagement can also be complicated when a peer specialist and clinician who know each other as "client" and "provider" meet as colleagues or co-workers of equal status (Mowbray 1996; Dixon 1997, Dixon 1994; Gates 2007; Paulson 1999; Davidson 1999).

E. 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.*

Appendix F: References

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G. History of Funding in Massachusetts

SERVICE	DMH Funding	Medicaid Funding	Date Started
Community-Based Flexible Supports	DMH	Federal Medicaid	2009
Emergency Service Programs (ESPs)	DMH	MassHealth via Massachustts Behavioral Health Partnership (MBHP)	2009
Recovery Learning Communities	DMH + grant funding		2009
Common Ground pilot: shared decision making with Dr. Deegan		MassHealth via MBHP	2009
The Transformation Center (statewide training, technical assistance and advocacy)	DMH	MassHeatlh via MBHP	2006
Enhanced Psychiatric Day Treatment		MBHP (performance incentive pilot)	2005
Worcester and Tewksbury State Hospital (Peer Debriefer)	DMH		2004
Programs for Assertive Community Treatment (PACT)	DMH	MBHP	2002 (peer role)
Peer Support and Aftercare (Peer Bridgers)		MBHP (in two DMH-funded clubhouses)	2002
Leadership Academy and peer-led provider trainings (The Transformation Center, previously M-POWER)	DMH	MBHP	2001
Dual Recovery Anonymous groups with MA Clubhouse Coalition		MBHP	2000
Partnering for Recovery Conference (now Recovery Forums)		MBHP	1999
Peer Educators Project		MBHP	1999
Massachusetts Consumer Satisfaction Team (now Consumer Quality Initiatives, Inc.)		MBHP	1998

The above chart does not include every peer support service, especially those originating in the late 1990's but we would like to acknowledge the groundbreaking work by the pioneers in those early years.